OHIO REGULATORY REQUIREMENTS MANUAL

Meridian Health Plan of Michigan, Inc. ("Plan") contracts with various network providers, hospitals, ancillary providers, specialists and other practitioners ("You" or "Provider"). To the extent that you are a Provider contracted with Plan, this Regulatory Requirements Manual (the "Manual") incorporates various sections required by law, regulation or a regulatory body into your agreement with Plan. The applicable sections of this Manual will control in the event of a conflict with your agreement. Meridian will update this Manual as there are changes to state and federal laws, regulations, guidance or in the case of Medicare or Medicaid (or other related program) requirements, as Meridian's agreements with Payors are revised. Nothing in this Manual or the Agreement releases you from any independent obligation to comply with applicable statutory or regulatory authority.

Without limiting the generality of the foregoing, and notwithstanding anything in the agreement to the contrary, Provider has agreed to comply with the applicable requirements based on the selected networks Provider has agreed to participate in with Plan:

Ohio Statutory/Regulatory Requirements

1. **Definitions.** Notwithstanding anything to the contrary in the Agreement, any term defined at Ohio Rev. Code § 1751.01 shall be interpreted consistent with the definition in the statute and any conflict between the capitalized term in the Agreement and Ohio Rev. Code § 1751.01 shall be resolved to ensure compliance with the statute.

2. **Enrollee Hold Harmless.** Provider agrees that in no event, including but not limited to nonpayment by the Plan, insolvency of the Plan, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against, a subscriber, Enrollee, person to whom Covered Services have been provided, or person acting on behalf of the Enrollee, for Covered Services provided pursuant to this Agreement. This does not prohibit Provider from collecting co-insurance, deductibles, or copayments as specifically provided in the evidence of coverage, or fees for uncovered health care services delivered on a fee-for-service basis to persons referenced above, nor from any recourse against the Plan or its successor. The provisions of this Section supersede any and all oral and written contrary Agreements now existing or hereafter entered into between Provider and any Enrollee or person acting on behalf of any Enrollee. This Section shall survive the termination of this Agreement with respect to services covered and provided under this Agreement during the time this Agreement was in effect, regardless of the reason for the termination, including insolvency of the Plan. [ORC § 1751.13]

3. **Termination of a Specific Participating Practitioner.** Pursuant to Ohio Rev. Code Chapter 1753, should Plan notify PP of intent to terminate, Plan shall develop a performance improvement plan in conjunction with PP. If, after being afforded the opportunity to comply with the performance improvement plan, the PP fails to do so, Plan may terminate PP's participation with Plan.

   A. **Appeal by Participating Practitioner of Termination for Cause**. PP may appeal the termination under Section 2 above to the appropriate Medical Director of Plan. The Medical Director shall give the PP an opportunity to discuss with the Medical Director the reason(s) for the termination. If a satisfactory resolution of PP's appeal cannot be reached, the PP may appeal the termination to a panel composed of Participating Providers who have comparable or higher levels of education and training than the PP making the appeal. A representative of the PP's specialty shall be a member of the panel, where feasible. This panel shall hold a hearing, and shall render its recommendation in the appeal within thirty (30) days after holding the hearing. The recommendation shall be presented to the Plan's Medical Director and to the PP. The Medical Director shall review and consider the panel's recommendation before making a final decision.

   B. **Participating Practitioner Status during Appeal.** PP shall remain a Participating Provider for purposes of this Agreement during the pendency of the appeal under Section 2(A) unless Plan determines in its sole discretion that PP's conduct presents an imminent risk of harm to an enrollee or enrollees; or if there has occurred unacceptable quality of care, fraud, patient abuse, loss of clinical privileges, loss of professional liability coverage, incompetence, or loss of authority to practice in the participating provider's field; or if a governmental action has impaired the participating provider's ability to practice.

   C. **Supremacy.** To the extent that this Section 2 complies with the Healthcare Quality Improvement Act of 1986, as amended, this Section 2 shall supersede and replace any conflicting term of Plan Policies, including the Quality Improvement Plan, for the subject matter described herein. Notwithstanding the generality of the preceding sentence, Plan Policies may be amended from time to time to correspond with changed or additional procedures required by state or federal law.

4. **Amendments.**

Definition: "Material Amendment" means an amendment to this Agreement that decreases Provider's payment or compensation, changes the administrative procedures in a way that may reasonably be expected to significantly increase the provider's administrative expenses, or adds a new product. Material Amendment does not include the following:

a) A decrease in payment or compensation resulting solely from a change in a published fee schedule upon which the payment or compensation is based and the date of applicability is clearly identified in the contract;

b) A decrease in payment or compensation that was anticipated under the terms of this Agreement, if the amount and date of applicability of the decrease is clearly identified in this Agreement;

c) An administrative change that may significantly increase the provider's administrative expense, the specific applicability of which is clearly identified in this Agreement;

d) Changes to an existing prior authorization, precertification, notification, or referral program that does not substantially increase the provider's administrative expense; and

e) Changes to an edit program or to specific edits if the Provider is provided notice of the changes fifteen (15) days prior to the effective date of the change and the notice includes information sufficient for the provider to determine the effect of the change.

A. Plan may amend this Agreement or any other documents, plans or policies (i.e. Quality Improvement Plan, Provider Manual, Utilization Review Plan) immediately if such amendment is necessary in order to comply with applicable governmental statutes and/or regulations, provided that Plan shall provide Provider with prompt written notice of such amendment. [ORC § 3963.04(C)]

B. Plan may amend this Agreement or any other documents, plans or policies, upon fifteen (15) days' written notice. Notwithstanding the foregoing, should Plan propose a Material Amendment and such Material Amendment is not covered by Subsection 4(A), above, Plan shall provide Provider ninety (90) days' written notice prior to the effectiveness of any proposed Material Amendment to this Agreement. Such notice shall include the terms of the Material Amendment. Provider may object to the terms of the Material Amendment within fifteen (15) days from Provider's receipt of the notice of the Material Amendment and notice. Plan and Provider shall negotiate the terms of the Material Amendment in good faith. If these negotiations do not result in a mutually satisfactory resolution of the objection, either party may terminate this Agreement upon written notice of termination provided to the other party at least sixty (60) days prior to the effective date of the Material Amendment, subject to the requirements of Section 6.4. [Ohio Rev. Code § 3963.04]

C. Notwithstanding anything to the contrary in this Section 2, if Plan determines in its sole discretion that: a) the delay caused by compliance with Subsections 4(A) or 4(C) could result in imminent harm to an Enrollee; b) that the Material Amendment is required by state or federal law, rule, or regulation, or c) where Provider affirmatively accepts the Material Amendment in writing and agrees to an earlier effective date than otherwise stated in the Material Amendment, such Material Amendment shall be effective immediately. [ORC § 3963.04(B)(1)]

D. Notwithstanding anything to the contrary in this Section 4, Plan need not notify Provider to implement an amendment to this Agreement to accomplish either of the following:

a) Plan may immediately amend this Agreement to modify the compensation due to Provider if Provider's compensation for a Product is based on the current Medicaid or Medicare physician fee schedule, and the change in payment or compensation results solely from a change to that fee schedule; and

b) Plan may immediately amend this Agreement to implement any addition, deletion, or revision of any Service Code, Procedure Code, or Reporting Code, or a pricing change is made by any Third Party Source.

i) The terms "Service Code, Procedure Code or Reporting Code" include all of the following: current procedural terminology (CPT), current dental terminology (CDT), the healthcare common procedure coding system (HCPCS), the international classification of diseases (ICD), or the drug topics redbook average wholesale price (AWP).

ii) The term "Third Party Source" includes all of the following: American Medical Association, American Dental Association, the Centers for Medicare and Medicaid Services, the National Center for Health Statistics, the Department of Health and Human Services Office of the Inspector General, the Ohio Department of Insurance, or the Ohio Department of Medicaid.

<u>Medicare Regulatory Requirements</u>

Where Provider provides services to Medicare Enrollees of Plan, the following provisions shall be incorporated into the Agreement and shall control where conflicting:

CMS requires that specific terms and conditions be incorporated into the Agreement between a Medicare Advantage Organization or First Tier Entity and a First Tier Entity or Downstream Entity to comply with the Medicare laws, regulations, and CMS instructions, including, but not limited to, the Medicare Prescription Drug, Improvement and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 ("MMA"); and

Except as provided herein, all other provisions of the Agreement between Plan and Provider not inconsistent herein shall remain in full force and effect.

Definitions:

Centers for Medicare and Medicaid Services ("CMS"): the agency within the Department of Health and Human Services that administers the Medicare program.

Completion of Audit: completion of audit by the Department of Health and Human Services, the Government Accountability Office, or their designees of a Medicare Advantage Organization, Medicare Advantage Organization contractor or related entity.

Downstream Entity: any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit, below the level of the arrangement between an MA organization (or applicant) and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

Final Contract Period: the final term of the contract between CMS and the Medicare Advantage Organization.

First Tier Entity: any party that enters into a written arrangement, acceptable to CMS, with an MA organization or applicant to provide administrative services or health care services for a Medicare eligible individual under the MA program.

Medicare Advantage ("MA"): an alternative to the traditional Medicare program in which private plans run by health insurance companies provide health care benefits that eligible beneficiaries would otherwise receive directly from the Medicare program.

Medicare Advantage Organization ("MA organization"): a public or private entity organized and licensed by a State as a risk-bearing entity (with the exception of provider-sponsored organizations receiving waivers) that is certified by CMS as meeting the MA contract requirements.

Member or Enrollee: a Medicare Advantage eligible individual who has enrolled in or elected coverage through a Medicare Advantage Organization.

Provider: (1) any individual who is engaged in the delivery of health care services in a State 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 in a State and is licensed or certified to deliver those services if such licensing or certification is required by State law or regulation.

Related entity: any entity that is related to the MA organization by common ownership or control and (1) performs some of the MA organization's management functions under contract or delegation; (2) furnishes services to Medicare enrollees under an oral or written agreement; or (3) leases real property or sells materials to the MA organization at a cost of more than $2,500 during a contract period.

Required Provisions:

Provider agrees to the following:

1. HHS, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any pertinent information for any particular contract period, including, but not limited to, any books, contracts, computer or other electronic systems (including medical records and documentation of the first tier, downstream, and entities related to CMS' contract with Plan, (hereinafter, "MA organization") through 10 years from the final date of the final contract period of the contract entered into between CMS and the MA organization or from the date of completion of any audit, whichever is later. [42 C.F.R. §§ 422.504(i)(2)(i) and (ii)]

2. Provider will comply with the confidentiality and enrollee record accuracy requirements, including: (1) abiding by all Federal and State laws regarding confidentiality and disclosure of medical records, or other health and enrollment information, (2) ensuring that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas, (3) maintaining the records and information in an accurate and timely manner, and (4) ensuring timely access by enrollees to the records and information that pertain to them. [42 C.F.R. §§ 422.504(a)(13) and 422.118]

3. Enrollees will not be held liable for payment of any fees that are the legal obligation of the MA organization. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)]

4. For all enrollees eligible for both Medicare and Medicaid, enrollees will not be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts. Providers will be informed of Medicare and Medicaid benefits and rules for enrollees eligible for Medicare and Medicaid. Provider may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under title XIX if the individual were not enrolled in such a plan. Providers will: (1) accept the MA plan payment as payment in full, or (2) bill the appropriate State source. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)]

5. Any services or other activity performed in accordance with a contract or written agreement by Provider are consistent and comply with the MA organization's contractual obligations. [42 C.F.R. § 422.504(i)(3)(iii)]

6. Contracts or other written agreements between the MA organization and providers or between first tier and downstream entities must contain a prompt payment provision, the terms of which are developed and agreed to by the contracting parties. The MA organization is obligated to pay contracted providers under the terms of the contract between the Plan and Provider. [42 C.F.R. §§ 422.520(b)(1) and (2)] In accordance with 42 C.F.R. § 422.520(b), Provider shall provide to Plan all information necessary for Plan to establish proper payment. Plan shall pay Provider for Covered Services rendered to Covered Persons in accordance with Section 7 of the Agreement. Any Clean Claim, as defined in 42 C.F.R. § 422.500, shall be paid within thirty (30) days of receipt by Plan at such address as may be designated by Plan, and Plan shall pay interest on any Clean Claim not paid within thirty (30) days of such receipt by Plan at the rate of interest required by law, or as otherwise set forth in the Provider Manual. Plan's payment of such interest shall be Provider's sole remedy for Plan's failure to pay a Clean Claim within the applicable time period and shall be inclusive of any applicable penalties.

7. Provider and any related entity, contractor or subcontractor will comply with all applicable Medicare laws, regulations, and CMS instructions. [42 C.F.R. §§ 422.504(i)(4)(v)]

8. If any of the MA organization's activities or responsibilities under its contract with CMS are delegated to any first tier, downstream and related entity:

(i) The delegated activities and reporting responsibilities are specified in the Agreement, if any.

(ii) CMS and the MA organization reserve the right to revoke the delegation activities and reporting requirements or to specify other remedies in instances where CMS or the MA organization determine that such parties have not performed satisfactorily.

(iii) The MA organization will monitor the performance of the parties on an ongoing basis.

(iv) The credentials of medical professionals affiliated with the party or parties will be either reviewed by the MA organization or the credentialing process will be reviewed and approved by the MA organization and the MA organization must audit the credentialing process on an ongoing basis.

(v) If the MA organization delegates the selection of providers, contractors, or subcontractor, the MA organization retains the right to approve, suspend, or terminate any such arrangement.
[42 C.F.R. §§ 422.504(i)(4) and (5)]

Medicaid Requirements

Where Provider provides services to Medicaid Enrollees of Plan, the following provisions shall be incorporated into the Agreement and shall control where conflicting:

Definitions:

"Medicaid" Medical assistance provided under a state plan approved under Title XIX of the Social Security Act.

"OAC" Ohio Administrative Code.

"ODI" means the Ohio Department of Insurance.

"ODJFS" means the Ohio Department of Job and Family Services.

"ODM" Ohio Department of Medicaid.

"ORC" Ohio Revised Code.

Required Provisions:

Providers providing health care services to Medicaid Enrollees agree to abide by all of the following specific terms:

1. Provider agrees with the exception of any Medicaid Enrollee co-payments Plan elected to implement in accordance with OAC rule 5160-26-12, Plan payment constitutes payment in full for any covered service and will not charge the Medicaid Enrollee or ODM any co-payment, cost sharing, down- payment, or similar charge, refundable or otherwise. This agreement does not prohibit Nursing Facilities (NFs) or waiver entities from collecting patient liability payments from Medicaid Enrollees as specified in OAC rule 5160:1-3-24 or Federally Qualified

Health Centers (FQHCs) and Rural Health Clinics (RHCs) from submitting claims for supplemental payments to ODM as specified in OAC rules 5160-28-07 and 5160-16-05.

A. Plan shall notify Provider whether Plan elected to implement any Medicaid Enrollee co- payments and if applicable under what circumstances Medicaid Enrollee co-payments are imposed in accordance with OAC rule 5160-26-12.

B. Provider agrees Medicaid Enrollee notification regarding any applicable co-payment amounts must be carried out in accordance with OAC rule 5160-26-12.

2. Provider agrees not to hold liable ODM and the Medicaid Enrollee in the event Plan cannot or will not pay for covered services performed by Provider pursuant to this Agreement with the exception that:

A. FQHCs and RHCs may be reimbursed by ODM in the event of Plan insolvency pursuant to Section 1902(bb) of the Social Security Act,

B. Provider may bill the Medicaid Enrollee when Plan has denied prior authorization or referral for the services and the following conditions are met:

i. The Medicaid Enrollee was notified by Provider of the financial liability in advance of service delivery;

ii. The notification by Provider was in writing, specific to the service being rendered, and clearly states that the Medicaid Enrollee is financially responsible for the specific service. A general patient liability statement signed by all patients is not sufficient for this purpose; and

iii. The notification is dated and signed by the Medicaid Enrollee.

3. Provider agrees to cooperate with Plan quality assessment and performance improvement (QAPI) program in all Plan provider subcontracts and employment agreements for physician and non-physician providers.

4. Plan shall disseminate written policies that include detailed information about the False Claims Act and other provisions named in 42 U.S.C. Section 1396a(a)(68), any related State laws pertaining to civil or criminal penalties, whistleblower protections under such laws, as well as Plan policies and procedures for detecting and preventing fraud, waste and abuse; and Provider agrees to abide by Plan written policies regarding the False Claims Act and the detection and prevention of fraud, waste and abuse.

5. Provider agrees to cooperate with the ODM external quality review as described in OAC Chapter 5160, including rule 5160-26-07.

6. The terms of this Agreement relating to the beginning date and expiration date or automatic renewal clause, as well as the applicable methods of extension, renegotiation and termination apply to this Agreement.

7. Notwithstanding item 6 of this Attachment B to the Agreement, Plan must give Provider at least sixty days prior notice for the nonrenewal or termination of this Agreement except in cases where an adverse finding by a regulatory agency or health or safety risks dictate that this Agreement be terminated sooner.

8. Notwithstanding item 6 of this Attachment B to the Agreement, Provider may non-renew or terminate this Agreement if one of the following occurs:

A. Provider gives Plan at least sixty days prior notice for the nonrenewal or termination of this Agreement. The effective date for the nonrenewal or termination must be the last day of the month; or

B. ODM proposed action in accordance with OAC Chapter 5160, including rule 5160-26-10(G), regardless whether the action is appealed. Provider’s nonrenewal or termination notice must be received by Plan within fifteen working days prior to the end of the month in which Provider is proposing nonrenewal or termination. If the notice is not received by this date, Provider must extend the nonrenewal or termination date to the last day of the subsequent month

9. The procedures to be employed upon the ending, nonrenewal, or termination specified in this Agreement, apply to this Agreement including an agreement to promptly supply all records necessary for the settlement of outstanding claims.

10. Notwithstanding Items 7 and 8 of this Attachment B to the Agreement, in the event of a hospital provider’s proposed non-renewal or termination of this Agreement, the hospital provider agrees to notify in writing all providers who have admitting privileges at the hospital of

the impending non-renewal or termination of this Agreement and the last date the hospital will provide services to Medicaid Enrollees under this Agreement. This notice must be sent at least forty-five days prior to the effective date of the proposed non-renewal or termination. If the hospital provider issues fewer than forty- five days prior notice to Plan, the notice to providers who have admitting privileges at the hospital must be sent within one working day of the hospital provider issuing notice of non- renewal or termination of this Agreement.

11. Provider agrees to release to Plan any information necessary for Plan to perform any of its obligations under the ODM provider agreement, including, but not limited to compliance with reporting and quality assurance requirements. Provider agrees the released information will be shared with ODM upon request to Plan.

12. Provider must supply, upon request, the business transaction information required under 42 C.F.R. 455.105.

13. Provider and all employees of Provider are duly registered, licensed or certified under applicable state and federal statutes and regulations to provide the health care services that are the subject of this Agreement and provider and all employees of Provider are not excluded from participating in federally funded health care programs.

14. If Provider is a Medicaid provider, provider must meet the qualifications specified in OAC Chapter 5160, including rule 5160-26-05(C).

15. All laboratory testing sites providing services to Medicaid Enrollees must have either a current Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver, certificate of accreditation, certificate of compliance, or a certificate of registration along with a CLIA identification number.

16. Home health providers must meet the eligible provider requirements specified in OAC Chapter 5160-12 and comply with the requirements for home care dependent adults as specified in section 121.36 of the Ohio Revised Code.

17. Provider shall be compensated pursuant to the method and in the amounts specified in Attachment B of the Agreement.

18. Provider agrees to provide services to all eligible Medicaid consumer populations as specified in the Ohio Department of Medicaid Provider Agreement. Indicate one or both:

☐Medicaid non-dual populations ☐MyCare Ohio Medicare/Medicaid populations

19. Provider agrees to provide services to MyCare Ohio consumers within the designated service area.

20. If Provider is a third party administrator (TPA), Provider agrees to include all elements of OAC rule 5160-26-05(D) in its subcontracts and will ensure that its subcontractors will forward information to ODM as requested.

21. Provider agrees to provide services as enumerated in Appendix V of this Agreement (within Provider's scope of practice).

22. Provider agrees to serve Medicaid Enrollees through the last day this Agreement is in effect.

23. Any amendment to the Appendix V and Attachment B specified in item 17 of the addendum must be agreed to in writing by both parties.

24. If provider is a primary care provider (PCP), provider agrees to participate in the care coordination requirements outlined in OAC Chapter 5160, including rule 5160-26-03.1.

25. Plan agrees not to prohibit, or otherwise restrict a provider acting within the lawful scope of practice, from advising or advocating on behalf of a Medicaid Enrollee who is his or her patient for the following:

A. The Medicaid Enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

B. Any information the Medicaid Enrollee needs in order to decide among all relevant treatment options.

C. The risks, benefits, and consequences of treatment versus non-treatment.

D. The Medicaid Enrollee'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.

26. Provider agrees in providing health care services to Medicaid Enrollees to identify and where indicated arrange, pursuant to the mutually agreed upon procedures between Plan and provider for the following at no cost to the Medicaid Enrollee:

A. Sign language services.

B. Oral interpretation and oral translation services.

27. Plan agrees to fulfill Provider's responsibility to mail or personally deliver notice of the Medicaid Enrollee's right to request a state hearing whenever Provider bills a Medicaid Enrollee due to Plan denial of payment of a Medicaid service, as specified in OAC Chapter 5160 including rule 5160-26-08.4, utilizing the procedures and forms as specified in OAC rule 5101:6-2-35.

28. Provider agrees to contact Plan designated twenty-four-hour post-stabilization services phone line to request authorization to provide post-stabilization services in accordance with OAC Chapter 5160, including rule 5160-26-03(G).

29. Provider agrees not to identify the addressee as a Medicaid consumer on the outside of the envelope when contacting Medicaid Enrollees by mail.

30. Provider agrees not to bill Medicaid Enrollees for missed appointments.

31. Provider shall not discriminate in the delivery of services based on the Medicaid Enrollee's race, color, religion, gender, sexual orientation, age, disability, national origin, military status, genetic information, ancestry, health status or need for health services.

32. Provider, in performance of the subcontract or in the hiring of any employees for the performance of services under the contract, shall not by reason of race, color, religion, gender, sexual orientation, age disability, national origin, military status, genetic information, health status or ancestry, discriminate against any citizen of Ohio in the employment of a person qualified and available to perform the services to which the subcontract relates.

33. Provider shall not in any manner discriminate against, intimidate, or retaliate against any employee hired for the performance of services under the subcontract on account of race, color, religion, gender, sexual orientation, age, disability, national origin, military status, genetic information, health status, or ancestry.

34. Provider shall be bound by the same standards of confidentiality which apply to ODM and the state of Ohio as described in OAC rule 5160:1-1-51.1 and 45 CFR Parts 160 and 164, including standards for unauthorized uses of or disclosures of protected health information (PHI).

35. Provider agrees their applicable facilities and records will be open to inspection by Plan, ODM or its designee, or other entities as specified in OAC rule 5160-26-06.

36. Provider agrees this Agreement is governed by, and is construed in accordance with all applicable laws, regulations, and contractual obligations of Plan.

A. ODM will notify Plan and Plan shall notify Provider of any changes in applicable state or federal law, regulations, waiver, or contractual obligation of Plan.

B. This Agreement shall be automatically amended to conform to such changes without the necessity for executing written amendments.

C. Plan shall notify Provider of all applicable contractual obligations.

37. Provider agrees to comply with the provisions for record keeping and auditing in accordance with OAC Chapter 5160-26.

38. Provider must retain and agrees to allow Plan access to all Medicaid Enrollee medical records for a period of not fewer than eight (8) years from the date of service or until any audit initiated within the eight year period is completed and allow access to all record keeping, audits, financial records, and medical records to ODM or its designee or other entities as specified in OAC rule 5160-26-06. At least three of the eight year-period of documentation must be readily available.

39. Provider agrees to make patient medical records for Medicaid eligible individuals available for transfer to new providers at no cost to the patient.

40. Notwithstanding anything in the Agreement to the contrary, Medicaid Enrollees shall not be held liable for Medicaid Covered Services under this Agreement provided to Medicaid Enrollee for which the State did not pay the ODJFS or ODJFS did not pay Plan, payment for Covered Services furnished under a contract, referral or other arrangement, to the extent that those payments are in excess of the amount that Medicaid Enrollee would owe if Plan provided the services directly, or services provided to Medicaid Enrollee for which the State or Plan did not pay Provider due to contractual, referral or other arrangement. Provider shall not deny services to any Medicaid Enrollee who is eligible for the services due to an Medicaid Enrollee's inability to pay a co-payment.

41. The Parties agree that Provider, in performing Provider's duties and obligations hereunder, shall have the right, subject to the credentialing and re-credentialing requirements described in this Agreement, either to employ its own employees and agents or to utilize the services of persons, firms and other entities by means of subcontractual relationships; provided, however, that no such subcontract shall operate to relieve Provider of its obligations hereunder and further provided that the format for all such subcontracts shall have been approved by the ODJFSFS or ODI in the event that either agency requires such approval; and further provided that Plan's liability for reimbursement hereunder shall extend only to Provider, and only to the sums provided for herein, and that Provider shall be solely responsible for reimbursement and/or payment of any employee or agent of Provider for services performed pursuant to this Agreement. All such subcontracts shall be in writing and fulfill requirements of 42 CFR 434.6 that are appropriate to the service or activity delegated under the subcontract.

Medicaid/Medicare - MyCare Ohio\Ohio Capitated Financial Alignment Demonstration Requirements

Where Provider provides services to MyCare Ohio\Ohio Capitated Financial Alignment Demonstration ("OFAD") Enrollees of Plan, the following provisions shall be incorporated into the Agreement and shall control where conflicting:

[RESERVED]