

**Practitioner Application**

**PLEASE COMPLETE ONE FORM PER PRACTITIONER IN PRACTICE**

Date

**Email scanned pdf of completed and signed form to AetnaBetterHealth-**

**VAProviderRelations@aetna.com/844-230-8829 Fax**

**Aetna Better Health** contracting standards require that **Aetna Better Health** obtain personal information such as your name, address, and social security number. Personal information is maintained in contracting database at **Aetna Better Health** for in-house tracking, reporting purposes, contracting and payment of claims. Failure to complete all fields may delay the contracting process.

IN ORDER TO BE CONTRACTED, **YOU MUST: HAVE AN INDIVIDUAL NPI NUMBER, BE REGISTERED WITH [MEDICAID] AGENCY, BE ELIGIBLE TO PARTICIPATE IN MEDICAID, SUBMIT CLAIMS ELECTRONICALLY, HAVE INTERNET ACCESS AND PARTICIPATE WITH ALL **Aetna Better Health** LINES OF BUSINESS.** W-9 forms for each Doing Business As (DBA) entity is required in order to establish/recognize all billing entities and/or the official Tax Identification Number (TIN) owner. Additionally, please note the establishment/recognition of multiple DBA/billing entities under one TIN require a unique billing NPI for each DBA/business entity.

**PROVIDER INFORMATION**

Last Name <input type="text"/>	First Name <input type="text"/>	M.I. <input type="text"/>	Degree <input type="text"/>	Title <input type="text"/>
Practice Name <input type="text"/>		Gender: <input type="radio"/> Male <input type="radio"/> Female		
Employment Start Date: <input type="text"/>	DOB <input type="text"/>		SSN <input type="text"/>	

Joining As: <input type="radio"/> Individual <input type="radio"/> Group <input type="radio"/> FQHC <input type="radio"/> RHC	An Existing Group <input type="checkbox"/> Yes <input type="checkbox"/> No A New Group <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you: <input type="radio"/> Office Based <input type="radio"/> Locum Tenens <input type="radio"/> Hospital Based Physician	<input type="radio"/> Hospitalist <input type="radio"/> Clinic <input type="radio"/> Health Dept <input type="radio"/> Urgent Care	Does your office utilize Physician Extenders? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide number of NP <input type="text"/> PA <input type="text"/>
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**PRACTICING SPECIALTIES**

Primary Specialty <input type="text"/>	Board Certified? <input type="checkbox"/> Yes <input type="checkbox"/> No
Other Specialties <input type="text"/>	Board Certified? <input type="checkbox"/> Yes <input type="checkbox"/> No
If not Board Certified, are you actively pursuing Board Certification? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you a Primary Care Physician? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, are you accepting new patients? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If closed panel, does PCP take family members of existing patients? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Maximum number of members accepted <input type="text"/>	
If a family practice provider, do you perform gynecology services? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Does your practice have gender limitations? <input type="checkbox"/> No <input type="checkbox"/> Yes, Male Only <input type="checkbox"/> Yes, Female Only	EPSDT Provider? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have age limits for practice? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what are the limits? <input type="text"/>	Does this provider location accommodate HIV/AIDs <input type="checkbox"/> Yes <input type="checkbox"/> No
Malpractice Coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No Limits <input type="text"/> FTCA: <input type="checkbox"/> Yes <input type="checkbox"/> No	Other: <input type="text"/>
Malpractice Carrier <input type="text"/>	Policy Number <input type="text"/>

**IDENTIFICATION NUMBERS AND LICENSE**

Group/Billing NPI <input type="text"/>	Individual NPI <input type="text"/>	DEA # <input type="text"/>
Group Medicaid # <input type="text"/>	Effective Date <input type="text"/>	Exp Date <input type="text"/>
Individual Medicaid # <input type="text"/>	Effective Date <input type="text"/>	State License # <input type="text"/>
Medicare # <input type="text"/>	Effective Date <input type="text"/>	Date First Issued <input type="text"/>
Electronic Prescribing? <input type="checkbox"/> Yes <input type="checkbox"/> No	CLIA Cert # <input type="text"/>	Exp Date <input type="text"/>
Telemedicine? <input type="checkbox"/> Yes <input type="checkbox"/> No	Other State License # <input type="text"/>	Taxonomies <input type="text"/>
	<input type="text"/>	

As a participant with the Council for Affordable Quality Healthcare (CAQH), Health Plan utilizes the CAQH uniform provider application.

I am registered with CAQH CAQH #

I would like to join CAQH

Please contact me about CAQH

**HOSPITAL / FREE STANDING SURGERY FACILITIES**

Active  Courtesy  Delivery  Provisional

Active  Courtesy  Delivery  Provisional

Active  Courtesy  Delivery  Provisional

Active  Courtesy  Delivery  Provisional

Indicate additional Affiliations or names on a separate attached sheet

Call Coverage Practice(s)/  
Physician Name(s)  
[must be registered with  
Medicaid Entity, if applicable]:

**GROUP MAILING**

Address  Suite

City  State  Zip

Phone  Fax

**BUSINESS INFORMATION**

Contact Name  Phone Number

Email  Fax Number

Electronic Claim Submission <input type="checkbox"/> Yes <input type="checkbox"/> No	Does business have internet access <input type="checkbox"/> Yes <input type="checkbox"/> No	Electronic Medical Records <input type="checkbox"/> Yes <input type="checkbox"/> No	Practice Website: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/>
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If no to either electronic submission or internet access, please explain:

**DEMOGRAPHIC INFORMATION**

(Patients want to know what makes you unique when selecting a provider)

Language(s) spoken other than English <input type="text"/>	Does this business offer services to the deaf/hearing impaired: <input type="checkbox"/> Yes <input type="checkbox"/> No	Is this business owned by a: <input type="checkbox"/> Minority Female <input type="checkbox"/> Disabled Person <input type="checkbox"/> None of the above	Cultural Heritage: <input type="checkbox"/> Asian <input type="checkbox"/> African-American/ Black <input type="checkbox"/> Hispanic/ Latino <input type="checkbox"/> Caucasian/ White Native <input type="checkbox"/> American <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Other <input type="text"/>
	Services: Sign Language <input type="checkbox"/> TTD/TTY <input type="checkbox"/> None of the above <input type="checkbox"/>	<input type="checkbox"/>	

**PRIMARY ADDRESS**  
(Main location where provider offers services)

Address <input style="width:50%;" type="text"/>		Suite <input style="width:50%;" type="text"/>	
City <input style="width:50%;" type="text"/>		State <input style="width:20%;" type="text"/>	Zip <input style="width:15%;" type="text"/>
County <input style="width:50%;" type="text"/>	Phone <input style="width:20%;" type="text"/>	Toll Free Phone <input style="width:20%;" type="text"/>	On Bus Route <input type="checkbox"/> Yes <input type="checkbox"/> No
			Evening Hours <input type="checkbox"/> Yes <input type="checkbox"/> No
			Weekend Hours <input type="checkbox"/> Yes <input type="checkbox"/> No
Fax <input style="width:20%;" type="text"/>	Email Address <input style="width:50%;" type="text"/>		Handicap Accessible <input type="checkbox"/> Yes <input type="checkbox"/> No
			Accommodate Special Needs Patients: Developmentally Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No
			Physically Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No
Office Hours	Wed <input style="width:20%;" type="text"/>	Sat <input style="width:20%;" type="text"/>	Is business equipped with adjustable exam table <input type="checkbox"/> Yes <input type="checkbox"/> No
Mon <input style="width:20%;" type="text"/>	Thur <input style="width:20%;" type="text"/>	Sun <input style="width:20%;" type="text"/>	
Tues <input style="width:20%;" type="text"/>	Fri <input style="width:20%;" type="text"/>		
Would you like this location in the provider directory <input type="checkbox"/> Yes <input type="checkbox"/> No			How do you provide 24/7 service <input style="width:50%;" type="text"/>

**ADDITIONAL OFFICE**  
(Indicate other offices on a separate sheet)

Address <input style="width:50%;" type="text"/>		Suite <input style="width:50%;" type="text"/>	
City <input style="width:50%;" type="text"/>		State <input style="width:20%;" type="text"/>	Zip <input style="width:15%;" type="text"/>
County <input style="width:50%;" type="text"/>	Phone <input style="width:20%;" type="text"/>	Toll Free Phone <input style="width:20%;" type="text"/>	On Bus Route <input type="checkbox"/> Yes <input type="checkbox"/> No
			Evening Hours <input type="checkbox"/> Yes <input type="checkbox"/> No
			Weekend Hours <input type="checkbox"/> Yes <input type="checkbox"/> No
Fax <input style="width:20%;" type="text"/>	Email Address <input style="width:50%;" type="text"/>		Handicap Accessible <input type="checkbox"/> Yes <input type="checkbox"/> No
			Accommodate Special Needs Patients: Developmentally Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No
			Physically Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No
Office Hours	Wed <input style="width:20%;" type="text"/>	Sat <input style="width:20%;" type="text"/>	Is business equipped with adjustable exam table <input type="checkbox"/> Yes <input type="checkbox"/> No
Mon <input style="width:20%;" type="text"/>	Thur <input style="width:20%;" type="text"/>	Sun <input style="width:20%;" type="text"/>	
Tues <input style="width:20%;" type="text"/>	Fri <input style="width:20%;" type="text"/>		
Would you like this location in the provider directory <input type="checkbox"/> Yes <input type="checkbox"/> No			How do you provide 24/7 service <input style="width:50%;" type="text"/>

**PAYMENT INFORMATION**

(This information must be the same as the W-9 information provided. Contract and remits will be mailed to this address unless otherwise specified)

Practice Name <input style="width:50%;" type="text"/>		Tax ID Number <input style="width:50%;" type="text"/>	
DBA Name <input style="width:100%;" type="text"/>			
Address <input style="width:50%;" type="text"/>		Suite <input style="width:50%;" type="text"/>	
City <input style="width:50%;" type="text"/>		State <input style="width:20%;" type="text"/>	Zip <input style="width:15%;" type="text"/>
County <input style="width:50%;" type="text"/>	Phone <input style="width:20%;" type="text"/>	Fax <input style="width:20%;" type="text"/>	Toll Free Phone <input style="width:20%;" type="text"/>
Billing Contact <input style="width:50%;" type="text"/>		Billing Email <input style="width:50%;" type="text"/>	

**The completion of this form does not guarantee network participation.** Please allow approximately 21 days to evaluate the application and allow **Aetna Better Health** to verify that a CAQH application has been completed; please allow approximately 90 days to complete the credentialing process.

I am  of  and authorized to submit this application on behalf of .  
 I affirm that all of the information on this form is accurate and complete to the best of my knowledge, information, and belief. I Promise to keep confidential any information that **Aetna Better Health** shares with me during this process.

Authorized Signature  Date



**Provider & Subcontractor Disclosure of Ownership & Controlling Interest Worksheet**

To comply with Federal law (42 CFR 455.100–106), health plans with Medicaid business must obtain certain information about the ownership and control of entities with which the health plan contracts for services for which payment is made under the Medicaid program.

The Centers for Medicare & Medicaid Services and the State Medicaid agency require Aetna (including Coventry and First Health) to obtain this information to show that we are not contracting with an entity that has been excluded from Federal health programs, or with an entity that is owned or controlled by an individual who has been convicted of a criminal offense, has had civil monetary penalties imposed against them, or has been excluded from participation in Medicare or Medicaid.

We require this form if you want to or keep participating with Aetna. You must promptly report any future changes to this information, and in no event more than 35 days after any such change, to the health plan. Use more blank sheets of paper if you need space to continue your responses. If you have questions, please contact the health plan.

**If the practice group with which the Provider belongs has completed this form within the previous 180 days, and can certify that no information on the form he/she sent previously has changed, you can initial below. Leave the “Disclosure of Ownership & Control Interest” Section of this Worksheet blank. Otherwise, you must complete all fields.**

\_\_\_\_\_ I hereby certify that the information in the ownership and controlling interest worksheet that the practice group submitted within the previous 180 days is still complete and accurate.

**Identifying information of provider/subcontractor**

Name of provider/subcontractor: \_\_\_\_\_

Type of provider/subcontractor: \_\_\_\_\_

Tax ID #: \_\_\_\_\_ NPI #: \_\_\_\_\_

Medicaid provider ID #: \_\_\_\_\_

Primary business address: \_\_\_\_\_

**If the provider is no longer affiliated with this tax ID#, please check this box and sign and date the second page.**

**If the primary business address has changed, please provide new address and continue.**

\_\_\_\_\_

Additional business locations, including PO boxes, if applicable: \_\_\_\_\_

Type of ownership: \_\_\_\_\_ (examples may include: partnership, corporation, government, limited partnership, corporate-owned, investor-owned, etc.)

**Disclosure of Ownership & Control Interest (Use & attach more sheets of paper if necessary)**

- a) List any individual or organization (hereinafter referred to as “Person”) & their address that has a direct or indirect ownership or control interest of 5 percent or more in your entity (hereinafter referred to as “Interest”). If the Person with the interest is a corporation, please include (i) the primary business address, (ii) every business location; (iii) PO box addresses, if applicable; and (iv) the tax identification number. If the person with the interest is an individual (this includes officers and directors of the corporation, or partners in the case of a partnership), list the individual’s name, date of birth and Social Security number.

\_\_\_\_\_

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

b) For any person disclosed above in (a) with an ownership or control interest, list whether such person is related to another person with ownership or control interest in your entity as a spouse, parent, child or sibling.

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

c) For any person disclosed above in (a), list the name(s) of any other disclosing entity (defined as a Medicaid/Medicare provider, other than an individual practitioner or group of practitioners, or any entity that is otherwise required to disclose certain ownership and control information because of participation in a Federal health care program) in which such person has an ownership or control interest.

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**For each service location:**

d) List any managing employees and their address, date of birth and Social Security number. Managing employees are individuals such as general managers, business managers, administrators or directors who exercise operational or managerial control over the entity or part thereof, or directly/indirectly conduct the daily operations of the entity, or part thereof.

Primary service address: \_\_\_\_\_

_____	_____
_____	_____
_____	_____
_____	_____

Service address #2: \_\_\_\_\_

_____	_____
_____	_____
_____	_____
_____	_____

Service address #3: \_\_\_\_\_

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company and its affiliates (Aetna).

_____	_____
_____	_____
_____	_____
_____	_____

*Repeat for all service addresses covered under this provider/tax ID#. Any service addresses not listed will be considered nonparticipating for Medicaid.*

e) Has there been a change in ownership or control within the last year? \_\_\_\_\_ If yes, give date  
\_\_\_\_\_

f) Has any person listed on this form ever been excluded from Federal health programs, had civil monetary penalties imposed against them, or been convicted of a crime related to that person's involvement in any program under Medicaid, Medicare, or Title XX programs? \_\_ Yes \_\_ No

**If yes, list those persons below in addition to the exclusion type, date of exclusion and date the exclusion ended, as applicable:**

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Check if you listed more information on other pages

**I certify that the information contained above is true, complete and accurate. If you knowingly and willfully fail to fully and accurately disclose the information requested, the Plan may deny your request to join the network.**

**Signed:** \_\_\_\_\_  
**Date:** \_\_\_\_\_

**Print:** \_\_\_\_\_  
**Title:** \_\_\_\_\_

**Coventry Health Care of Virginia, Inc. d/b/a Aetna Better Health® of Virginia**

**Medicaid Provider / Group Agreement Checklist**

\_\_\_\_\_ **All** pages of this document must be printed and returned to Coventry Health Care of Virginia (not just the signature pages).

\_\_\_\_\_ **Page 1.** The Provider/Group name that is filled in on the top of page one must match **exactly** with the name on the W9. **Leave the effective date blank.** This will be filled in by Coventry Health Care of Virginia.

\_\_\_\_\_ **Signature Page.** The signature page must be signed by an appropriate Provider/Group representative. The other information (TIN, NPI, and Reimbursement Address) must be completely filled in.

\_\_\_\_\_ **Provider Roster.** The Provider/Group must complete and submit Aetna Better Health's Provider Roster template.

\_\_\_\_\_ **Individual Provider Addendum – Include if Applicable.** For Provider Groups, the Provider Group name that is filled in on the top must match **exactly** with the name on the W9. The Individual Provider Addendum must be signed by the appropriate Provider, dated and include the Provider's NPI Number. Individual Provider Addenda are not necessary if the Group's single signatory has legal authority to bind the individual providers.

\_\_\_\_\_ **Provider Application.** The Aetna Better Health Provider Application must be returned with the contract.

\_\_\_\_\_ **W9.** A W9 form must be returned with the contract. As indicated above, the name on the W9 must match exactly the name listed on pages 1 and the signature page of the Agreement.

**Please return all documents to:**

AETNA BETTER HEALTH OF VIRGINIA  
ATTN: PROVIDER RELATIONS  
9881 MAYLAND DRIVE  
RICHMOND, VA 23233

## MEDICAID PROVIDER/GROUP AGREEMENT

The term of this Medicaid Provider/Group Agreement (“Agreement”) by and between Coventry Health Care of Virginia, Inc. d/b/a Aetna Better Health® of Virginia, a Virginia corporation, on behalf of itself and its Affiliates (hereinafter “Company”), and \_\_\_\_\_ (hereinafter “Group”), shall commence effective \_\_\_\_\_, 20\_\_ [Date to be completed by Company] (the “Effective Date”). Company and Group may be referred to individually as a “Party” and collectively as the “Parties.” For purposes of this Agreement, all references to “Group” shall also apply with equal force to an individual provider. The compliance addenda attached to this Agreement, are expressly incorporated into this Agreement and are binding upon the Parties. In the event of any inconsistent or contrary language between the compliance addenda and any other part of this Agreement, including but not limited to exhibits, attachments or amendments, the Parties agree that the provisions of the addenda shall prevail.

**WHEREAS**, Company administers Plans for Government Sponsors that provide access to health care services to Members or arranges for the provision of health care services to Members of Government Programs; and

**WHEREAS**, Company contracts with certain health care providers and facilities to provide access to such health care services to Members; and

**WHEREAS**, Participating Group Providers provide health care services to patients within the scope of their licensure or accreditation; and

**WHEREAS**, Company and Group mutually desire to enter into an arrangement whereby Group providers will become Participating Group Providers and will render health care services to Members; and

**WHEREAS**, in return for the provision of health care services by Participating Group Providers, Company will pay Group for Covered Services under the terms of this Agreement; and

**WHEREAS**, Group understands and agrees that Government Sponsors or other government entities may require certain changes to the terms of this Agreement before Group and Participating Group Providers can provide services to Members under the terms of any Plans that are awarded, by the Government Sponsors, to Company.

**NOW, THEREFORE**, in consideration of the foregoing and of the mutual covenants, promises and undertakings herein, the sufficiency of which is hereby acknowledged, and intending to be legally bound hereby, the parties agree as follows:

### 1.0 DEFINITIONS

When used in this Agreement, all capitalized terms shall have the following meanings:

**Affiliate.** Any corporation, partnership or other legal entity (including any Plan) directly or indirectly owned or controlled by, or which owns or controls, or which is under common ownership or control with Company.

**Clean Claim.** A claim that can be processed without obtaining additional information from the Group who provided the service or from a third party, except that it shall not mean a claim submitted by or on behalf of a Group who is under investigation for fraud or abuse, or a claim that is under review for medical necessity; provided, further, unless otherwise required by law or regulation, a claim which (a) is submitted within the proper timeframe as set forth in this Agreement and (b) has (i) detailed and descriptive medical and patient data, (ii) a corresponding referral (whether in paper or electronic format), if required for the applicable claim, (iii) whether submitted via an electronic transaction using permitted standard code sets (e.g., CPT-4, ICD-9 (or successor standard), HCPCS) as required by the applicable Federal or state regulatory authority (e.g., U.S. Dept. of Health & Human Services, U.S. Dept. of Labor, state law or regulation) or otherwise, all the data elements of the UB-04 or CMS-1500 (or successor standard) forms (including but not limited to Member identification number, national provider identifier (“NPI”), date(s) of service, complete and accurate breakdown of services), and (c) does not involve coordination of benefits, and (d) has no defect or error (including any new procedures with no CPT code, experimental procedures or other circumstances not contemplated at the time of execution of this Agreement) that prevents timely adjudication.

Coinsurance. A payment a Member is required to make under a Plan which is determined as a percentage of the lesser of: (a) the rates established under this Agreement; or (b) Participating Group Provider's usual, customary and reasonable billed charges.

Confidential Information. Any information that identifies a Member and is related to the Member's participation in a Plan, the Member's physical or mental health or condition, the provision of health care to the Member or payment for the provision of health care to the Member. Confidential Information includes, without limitation, "individually identifiable health information," as defined in 45 C.F.R. § 160.103 and "non-public personal information" as defined in laws or regulations promulgated under the Gramm-Leach-Bliley Act of 1999.

Copayment. A charge required under a Plan that must be paid by a Member at the time of the provision of Covered Services, or at such other time as determined by Participating Group Provider and which is expressed as a specific dollar amount.

Covered Services. Those health care services for which a Member is entitled to receive coverage under the terms and conditions of a Plan. The Parties agree that Company is obligated to pay for only those Covered Services that are determined to be medically necessary, as determined in accordance with the Member's applicable Plan.

Covering Provider. A Participating Group Provider designated to provide Covered Services to Members when a particular Participating Group Provider is unavailable (e.g. out of the office or on vacation).

Deductible. An amount that a Member must pay for Covered Services during a specified coverage period in accordance with the Member's Plan before benefits will be paid.

Effective Date. Defined in first paragraph of this Agreement.

Emergency Medical Condition. A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (a) placing the health of the individual (or, with respect to a pregnant woman, her pregnancy or health or the health of her fetus) in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part; or such other definition as may be required by applicable law.

Emergency Services. Covered Services furnished by a qualified provider and necessary to evaluate or stabilize an Emergency Medical Condition.

Government Programs. Plans operated and/or administered by Company pursuant to a State Contract.

Government Sponsor. A state agency or other governmental entity authorized to offer, issue and/or administer one or more Plans, and which, to the extent applicable, has contracted with Company to administer all or a portion of such Plan(s).

Group. Defined in first paragraph of this Agreement. All references to "Group" shall also apply with equal force to an individual provider, as applicable.

Initial Term. Defined in Section 6.1 of this Agreement.

Material Change. Any change in Policies that could reasonably be expected, in Company's determination, to have a material adverse impact on (i) Group's reimbursement for Provider Services or (ii) administration of Group's practice.

Medically Necessary or Medical Necessity. Health care services that a physician or other applicable health care provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site and

duration, and considered effective for the patient's illness, injury or disease; and (c) not primarily for the convenience of the patient, physician or other health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, or otherwise consistent with physician specialty society recommendation and the views of physicians practicing in relevant clinical areas and any other relevant factors.

Member. An individual covered by or enrolled in a Plan.

Participating Group Provider. Any physician, hospital, hospital-based physician, skilled nursing facility, mental health and/or substance abuse professional (which shall include psychiatrists, psychologists, social workers, psychiatric nurses, counselors, family or other therapists or other mental health/substance abuse professionals), or other individual or entity involved in the delivery of health care or ancillary services who or which has entered into and continues to have a current valid contract with Company to provide Covered Services to Members, and, where applicable, has been credentialed by Company or its designee consistent with the credentialing policies of Company or its designee, as applicable. Certain categories of Participating Group Providers may be referred to herein more specifically as, e.g., "Participating Physicians" or "Participating Hospitals."

Party. Company or Group and Participating Group Providers, as applicable. Company and Participating Group Providers may be referred to collectively as the "Parties."

Provider Services. Defined in Section 2.1 of this Agreement.

Plan. A Member's health care benefits as set forth in the State Contract. Such Plans are listed in the **Program Participation Schedule** attached hereto and made a part hereof.

Policies. The policies and procedures promulgated by Company which relate to the duties and obligations of the Parties under the terms of this Agreement, including, but not limited to: (a) quality improvement/management; (b) utilization management, including, but not limited to, precertification of elective admissions and procedures, concurrent review of services and referral processes or protocols; (c) pre-admission testing guidelines; (d) claims payment review; (e) member grievances; (f) Provider credentialing; (g) electronic submission of claims and other data required by Company; and (h) any applicable participation criteria required by the State in connection with the Government Programs. Policies also include those policies and procedures set forth in the Company's and/or Government Sponsor's manuals (as modified from time to time) as Company determines appropriate in its sole discretion; clinical policy bulletins made available via Company's internet web site; and other policies and procedures, whether made available via a password-protected web site for Participating Group Providers (when available), by letter, newsletter, electronic mail or other media.

Post-Stabilization Care Services. Covered Services relating to an Emergency Medical Condition that are provided after a Member is stabilized in order to maintain the stabilized condition, or, under circumstances defined in federal regulations, to improve or resolve the Member's condition, pursuant to 42 CFR §422.113(c)(1), Social Security Act §1852(d)(2) and 42 CFR §438.114(a).

Primary Care Provider ("PCP"). A Participating Group Provider whose area of practice and training is family practice, general medicine, internal medicine or pediatrics, or who is otherwise designated as a Primary Care Provider by Company, and who has agreed to provide primary care services and to coordinate and manage all Covered Services for Members who have selected or been assigned to such Participating Group Provider, if the applicable Plan provides for a Primary Care Provider. This term may also include a nurse practitioner and/or physician assistant practicing within the applicable scope of practice, provided such provider meets Company standards and Policies.

Proprietary Information. Any and all information, whether prepared by a Party, its advisors or otherwise, relating to such Party or the development, execution or performance of this Agreement whether furnished prior to or after the Effective Date. Proprietary Information includes but is not limited to, with respect to Company, the development of

a pricing structure, (whether written or oral) all financial information, rate schedules and financial terms which relate to Group and which are furnished or disclosed to Group by Company. Notwithstanding the foregoing, the following shall not constitute Proprietary Information:

- (a) information which was known to a receiving Party (a “Recipient”) prior to receipt from the other Party (a “Disclosing Party”) (as evidenced by the written records of a Recipient);
- (b) information which was previously available to the public prior to a Recipient’s receipt thereof from a Disclosing Party;
- (c) information which subsequently became available to the public through no fault or omission on the part of a Recipient, including without limitation, the Recipient’s officers, directors, trustees, employees, agents, contractors and other representatives;
- (d) information which is furnished to a Recipient by a third party which a Recipient confirms, after due inquiry, has no confidentiality obligation, directly or indirectly, to a Disclosing Party; or
- (e) information which is approved in writing in advance for disclosure or other use by a Disclosing Party.

Specialty Program. A program for a targeted group of Members with certain types of illnesses, conditions, cost or risk factors.

Specialty Program Providers. Those hospitals, physicians and other providers that have been identified or designated by Company or the Government Sponsor to provide Covered Services associated with a Specialty Program.

State Contract. Company’s contract(s) with Government Sponsors to administer Plans or Government Programs identified in the **Program Participation Schedule**.

## **2.0 GROUP AND PARTICIPATING GROUP PROVIDER SERVICES AND OBLIGATIONS**

### **2.1 Provision of Services.**

Group shall provide to Members, through Participating Group Providers, those Covered Services which are within the scope of the respective Participating Group Provider’s license and certification to practice (“Provider Services”). Participating Group Providers may not provide any Covered Services to Members unless and until Participating Group Providers have been fully credentialed and approved by Company or its designee.

### **2.2 Non-Discrimination and Equitable Treatment of Members.**

Group and Participating Group Providers agree to provide Provider Services to Members with the same degree of care and skill as customarily provided to Participating Group Providers’ patients who are not Members, according to generally accepted standards of practice. Group and Participating Group Providers and Company agree that Members and non-Members should be treated equitably. Group and Participating Group Providers agree not to discriminate against Members on the basis of race, ethnicity, gender, creed, ancestry, lawful occupation, age, religion, marital status, sexual orientation, mental or physical disability, color, national origin, place of residence, claims experience, evidence of insurability (including conditions arising out of acts of domestic violence), genetic information, health status, source of payment for services, cost or extent of Provider Services required, or any other grounds prohibited by law or this Agreement and will abide by Company’s cultural competency Policies. Group and Participating Group Providers shall deliver Covered Services in a culturally competent manner to Members, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds, and comply with Company’s Policies on cultural competency.

### **2.3 Federal Law.**

Company is a Federal contractor and an Equal Opportunity Employer which maintains an Affirmative Action Program. To the extent applicable to Provider, Provider, on behalf of itself and any subcontractors, agrees to

comply with the following, as amended from time to time: Title XIX of the federal Social Security Act, 42 U.S.C. 1396 et seq., and regulations promulgated thereunder, Executive Order 11246, the Vietnam Era Veterans Readjustment Act of 1974, the Drug Free Workplace Act of 1988, Section 503 of the Rehabilitation Act of 1973, Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) administrative simplification rules at 45 CFR parts 160, 162, and 164, the Americans with Disabilities Act of 1990, Federal laws, rules and regulations designed to prevent or ameliorate fraud, waste, and abuse, including, but not limited to, applicable provisions of Federal criminal law, the False Claims Act (31 U.S.C. 3729 et. seq.), and the anti-kickback statute (Section 1128B(b) of the Social Security Act) and any similar laws, regulations or other legal mandates applicable to recipients of federal funds and/or transactions under or otherwise subject to any government contract of Company.

#### 2.4 Referrals.

To the extent required by the terms of the applicable Plan, Group shall refer or admit Members only to Participating Group Providers for Covered Services, and shall furnish such Participating Group Providers with complete information on treatment procedures and diagnostic tests performed prior to such referral or admission. In addition, to the extent possible, Group shall refer Members with out of network benefits, if any, to Participating Group Providers. Group shall be liable for any expenses resulting from a referral to a non-Participating Group Provider that Company did not pre-certify in advance, as permitted by applicable law.

#### 2.5 Group and Participating Group Provider Representations.

2.5.1 General Representations. Group represents, warrants and covenants, as applicable, that: (a) it and Participating Group Providers have, and shall maintain throughout the term of this Agreement all appropriate license(s) and certification(s) mandated by governmental regulatory agencies, which for each Participating Group Provider shall include, without limitation, DEA certification, certification to participate in the Medicaid and Medicare programs, and an unrestricted license to practice medicine in the state(s) in which such Participating Group Provider maintains offices and provides Provider Services to Members; (b) each Participating Group Provider is board certified or board eligible in the Specialty for which they provide Provider Services; (c) it and Participating Group Providers are, and will remain throughout the term of this Agreement, in compliance with all applicable Federal and state laws and regulations related to this Agreement and the services to be provided hereunder, including, without limitation, statutes and regulations related to fraud, abuse, discrimination, disabilities, confidentiality, self-referral, false claims and prohibition of kickbacks; (d) each Participating Group Provider has and shall maintain throughout the term of this Agreement unrestricted hospital privileges at a Participating Hospital; (e) it is legally authorized to negotiate on behalf of Participating Group Providers and to bind those Participating Group Providers to abide by the terms of this Agreement, as amended from time to time; (f) this Agreement has been executed by its duly authorized representative; and (g) executing this Agreement and performing its obligations hereunder shall not cause Group nor Participating Group Providers to violate any term or covenant of any other agreement or arrangement now existing or hereinafter executed.

2.5.2 Qualified Personnel. Group also represents that Group and Participating Group Providers have established an ongoing quality assurance/assessment program which includes, but is not limited to, credentialing of employees and subcontractors. Group shall supply to Company the relevant documentation, including, but not limited to, internal quality assurance/assessment protocols, state licenses and certifications, Federal agency certifications and/or registrations upon request. Group further represents that all personnel employed by, associated or contracted with Group and Participating Group Providers who treat Members: (a) are and shall remain throughout the term of this Agreement appropriately licensed and/or certified and supervised (when and as required by state and Federal law), and qualified by education, training and experience to perform their professional duties; and (b) shall act within the scope of their licensure or certification, as the case may be. Company may audit Group and Participating Group Providers compliance with this section upon prior written notice. Group is prohibited from using any individual or entity (“Offshore Entity”) (including, but not limited

to, any employee, contractor, subcontractor, agent, representative or other individual or entity) to perform any services for Plans if the individual or entity is physically located outside of one of the fifty United States or one of the United States Territories (i.e., American Samoa, Guam, Northern Marianas, Puerto Rico, and Virgin Islands), unless Company, in its sole discretion and judgment, agrees in advance and in writing to the use of such Offshore Entity. Group further agrees that Company has the right to audit any Offshore Entity prior to the provision of services for Plans.

2.5.3 Government Program Representations. Company has or shall seek contracts to serve beneficiaries of Government Programs. To the extent Company participates in a specific Government Program, Group and Participating Group Providers agree, on behalf of themselves and any subcontractors of Group or Participating Group Providers, to be bound by all rules and regulations of, and all requirements applicable to, such Government Programs. Group and Participating Group Providers acknowledge and agree that all provisions of this Agreement shall apply equally to any employees, independent contractors and subcontractors of Group and Participating Group Providers who provide or may provide Covered Services to Members of Government Programs, and Group and Participating Group Providers represent and warrant that Group and Participating Group Providers shall cause such employees, independent contractors and subcontractors to comply with this Agreement, the State Contract, and all applicable laws, rules and regulations and perform all requirements applicable to Government Programs. Any such subcontract or delegation shall be subject to prior written approval by Company. With respect to Members of Government Programs, Group and Participating Group Providers acknowledge that compensation under this Agreement for such Members constitutes receipt of Federal funds. Group and Participating Group Providers agree that all services and other activities performed by Group and Participating Group Providers under this Agreement will be consistent and comply with the obligations of Company and/or Government Sponsor under its contract(s) with CMS, and any applicable state regulatory agency, to offer Government Programs. Group and Participating Group Providers further agree to allow Government Sponsor, CMS, any applicable state regulatory agency, and Company to monitor Group and Participating Group Providers' performance under this Agreement on an ongoing basis in accordance with applicable laws, rules and regulations. Group and Participating Group Providers acknowledge and agree that Company may only delegate its activities and responsibilities under the State Contract or any Company contract(s) with Government Sponsor, CMS and any applicable regulatory agency, to offer Government Programs in a manner consistent with applicable laws, rules and regulations, and that if any such activity or responsibility is delegated by Company to Group and Participating Group Providers, the activity or responsibility may be revoked if Government Sponsor, CMS or Company determine that Group and Participating Group Providers have not performed satisfactorily. Upon request, Group or Participating Group Provider shall immediately provide to Company any information that is required by Company to meet its reporting obligations to CMS, including without limitation, physician incentive plan information, if applicable. To the extent that Group or Participating Group Providers generates and/or compiles and provides any data to Company that Company, in turn, submits to CMS, Group and Participating Group Providers certify, to the best of their knowledge and belief, that such data is accurate, complete and truthful.

2.5.4 Suspension or Debarment. Group represents, warrants and covenants, as applicable, that it and each Participating Group Provider:

- a. Has not within a three year period preceding the proposal submission been convicted or had a civil judgment rendered against him/her/it for commission of fraud or criminal offense in performing a public transaction or contract (local, state or federal) or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements or receiving stolen property; and
- b. Is not presently indicted for or otherwise criminally or civilly charged by a governmental entity with the commission of any of the above offenses; and
- c. Has not within a five year period preceding execution of this Agreement had one or more public transactions terminated for cause or fault; and
- d. Is not excluded, debarred or suspended from participation in any government-sponsored program

including, but not limited to, Government Programs, the Medicaid program in any state or Medicare; and

- e. Will immediately report any change in the above status to Company; and
- f. Will maintain all appropriate licenses to perform its duties and obligations under this Agreement.

## 2.6 Participating Group Providers.

Notwithstanding any contrary interpretation of this Agreement or of any contracts between Group and Participating Group Providers, Group acknowledges and agrees that all provisions of this Agreement applicable to Group shall apply with equal force to Participating Group Providers, unless clearly applicable only to Group. Group agrees that it is Group's responsibility to assure that the obligations of Participating Group Providers under this Agreement are fully satisfied, that Group will take all steps necessary to cause Participating Group Providers to comply with and perform the terms and conditions of this Agreement, and that Group's failure to do so shall constitute a material breach of this Agreement by Group. Group agrees, and shall require Participating Group Providers to agree, that in the event of any inconsistency between this Agreement and any contracts entered into between Group and Participating Group Providers, the terms of this Agreement shall control. Participating Group Providers shall accept compensation solely from Group for services rendered to Members under the terms of this Agreement, and shall in no event bill Company, Government Sponsor or Members for any such services (except for any Copayments, Coinsurance or Deductibles, if any, that Members may be required to pay for certain Covered Services). Group warrants and represents that it has the authority to bind each Participating Group Provider to the terms of this Agreement. Upon request by Company, Group shall provide copies of its contracts with Participating Group Providers, if any, to Company. Group shall obtain, if applicable, a signed Individual Provider Addendum from each Participating Group Provider in the form attached hereto.

## 2.7 Group Capacity.

If Company determines at any time that Members' access to Participating Group Providers is unacceptable due to any reduction in the number of Participating Group Providers, or any change in the types or geographic mix of Participating Group Providers, Company may request that Group take corrective action acceptable to Company within thirty (30) days. If Group fails to take such corrective action within such thirty (30) day period, Company may terminate this Agreement as provided in Section 6.3.

## 2.8 Participating Group Providers' Information.

Group shall provide to Company a complete list of Participating Group Providers, including names, office addresses, office hours, telephone and facsimile numbers, and area of practice or specialty. Group shall notify Company in writing within ten (10) business days of its acquiring knowledge of any change in this information. Group shall provide to Company at least one hundred twenty (120) days prior notice (or, if Group does not receive at least one hundred twenty (120) days notice, then such notice as Group actually receives of the termination of Group's relationship with a Participating Group Provider. Group shall obtain a completed credentialing application to become a Participating Group Provider from each of Group's providers, and shall, at Company's request, make available to Company any credentialing material held by or accessible to Group. Group shall obtain all necessary releases from Participating Group Providers to permit Group to release said credentialing files to Company, and Company shall be entitled to presume that such releases have been obtained.

## 2.9 Administrative Obligations of Primary Care Providers.

Each Participating Group Provider who is a Primary Care Provider shall comply with the following, to the extent required under the terms of the applicable Plan:

- 2.9.1 Coordination of Care. A Primary Care Provider shall arrange and coordinate the overall provision of Covered Services to Members under the terms and conditions of the Member's applicable Plan. A Primary Care Provider shall provide or arrange for the provision of Covered Services, including, without limitation, Emergency Services, regardless of whether a Participating Group Provider has previously seen or treated the Member.

2.9.2 Closed Panel. Group and Participating Group Providers and Company agree that a broad selection of physicians is important to Members and that Members expect physicians listed in Company's directories to be available to them. Accordingly, only upon at least ninety (90) days prior written notice with good cause acceptable to Company may a Participating Group Provider prospectively decline to accept new Members as patients. To prevent discrimination against Company or its Members, for such time as a Participating Group Provider declines to accept new Members as patients, such Participating Group Provider shall not accept as patients additional members from any entity or organization which competes with Company.

2.10 Administrative Obligations of Participating Group Providers Other than Primary Care Providers.

A Participating Group Provider who is not a Primary Care Provider shall: (a) except for Emergency Services, to the extent a referral is required by the applicable Plan, provide Covered Services to Members only upon prior referral of such patients by a Primary Care Provider to said Participating Group Provider on prescribed forms or by electronic means as instructed by Company; (b) except for Emergency Services and Post-Stabilization Care Services, to the extent required by the applicable Plan, render services to Members only at those inpatient, extended care, and ancillary service facilities which have been approved in advance by Company; and (c) promptly submit a report on the treatment of each Member to the referring Primary Care Provider, if applicable. Except for Emergency Services, payment for retroactive referrals shall be subject to adjustment or denial by Company.

2.11 Group and Participating Group Providers' Insurance.

2.11.1 Group's Insurance. During the term of this Agreement, Group agrees to procure and maintain such policies of general and professional liability and other insurance, or a comparable program of self-insurance, at minimum levels as required by state law or, in the absence of a state law specifying a minimum limit, an amount customarily maintained by Group in the state or region in which the Group operates. Such insurance coverage shall cover the acts and omissions of Group as well as those Group and Participating Group Providers' agents and employees. Group agrees to deliver certificates of insurance or other documentation as appropriate to show evidence of such coverage to Company upon request. Group agrees to make best efforts to provide to Company at least thirty (30) days advance notice, and in any event will provide notice as soon as reasonably practicable, of any cancellation or material modification of said policies.

2.11.2 Participating Group Providers' Insurance. During the term of this Agreement, each Participating Group Provider agrees to procure and maintain such policies of general and professional liability and other insurance, or a comparable program of self-insurance, at minimum levels as required by state law or, in the absence of a state law specifying a minimum limit, an amount customarily maintained by Group in the state or region in which the Group operates. Such insurance coverage shall cover the acts and omissions of Participating Group Provider as well as Participating Group Provider's agents and employees. Participating Group Provider agrees to deliver certificates of insurance or other documentation as appropriate to show evidence of such coverage to Company upon request. Participating Group Provider agrees to make best efforts to provide to Company at least thirty (30) days advance notice, and in any event will provide notice as soon as reasonably practicable, of any cancellation or material modification of said policies.

2.12 Program Participation.

Group and Participating Group Providers agree to participate in the Plans and other health benefit programs listed on the **Program Participation Schedule**. Company reserves the right to introduce and designate Group's participation in new Plans, Specialty Programs and other programs during the term of this Agreement and will provide Group with written notice of such new Plans, Specialty Programs and other programs and the associated compensation. To the extent that Company establishes and/or participates in a provider Pay-for-Performance incentive program or Performance Improvement Programs, Group agrees to comply with and participate in such program.

Nothing herein shall require that Company identify, designate or include Group and Participating Group Providers as a preferred participant in any specific Plan for which Company provides incentives based upon

the use of selected Participating Group Providers, Specialty Program or other program; provided, however, Group and Participating Group Providers shall accept compensation in accordance with this Agreement for the provision of any Covered Services to Members under a Plan, Specialty Program or other program in which Group and Participating Group Providers have agreed to participate hereunder.

2.13 Consents to Release Medical Information.

Group and Participating Group Providers covenant that they will obtain from Members to whom Provider Services are provided, any necessary consents or authorizations to the release of Information and Records to Company, Government Sponsors, their agents and representatives in accordance with any applicable Federal or state law or regulation or this Agreement.

2.14 Encounter Data.

For those services for which Group is compensated, Group and Participating Group Providers agree to provide Company with encounter data by type of Provider Service rendered to Members in the form and manner as specified by Company. There shall be no restrictions on Company's use of such encounter data. Furthermore, Company is under no obligation to return such encounter data to Group or Participating Group Providers.

Company is or may be required to obtain encounter data from Group and Participating Group Providers for Members, and Group and Participating Group Providers agree to provide complete and accurate encounter data to Company for Members that conforms to all standards and requirements set forth in applicable laws, rules and regulations, Government Sponsor and/or CMS instructions that apply to encounter data. Group and Participating Group Providers certify, based on best knowledge, information and belief, that any encounter data that Group and Participating Group Providers submit to Company for Members is accurate, complete and truthful. Group and Participating Group Providers agree to immediately notify Company if any encounter data that was submitted to Company for Members is erroneous, and follow procedures established by Company to correct erroneous encounter data to ensure Company's compliance with applicable laws, rules and regulations, and Government Sponsor and CMS instructions.

Group and Participating Group Providers further agree to maintain accurate, legible and complete medical record documentation for all encounter data submitted to Company for Members in a format that meets all standards and requirements set forth in applicable laws, rules, regulations, and/or Government Sponsor and CMS instructions, and allows any governmental authorities with jurisdiction or their designees ("Government Officials") to, in part: (1) confirm that the appropriate diagnoses codes and level of specificity are documented ; (2) verify the date of service is documented and within the encounter data collection period; and (3) confirm that the appropriate provider's signature and credentials are present ("Medical Records").

Group and Participating Group Providers agree to provide Company and Government Officials, or their designees, with medical records and any other information or documentation required by Government Officials for the validation of encounter data ("Audit Data"). Group and Participating Group Providers agree to provide Company with Audit Data within the timeframe established by Company to ensure Company's compliance with deadlines imposed by Government Officials for the submission of Audit Data. In the event that Government Sponsor or CMS conducts a review that includes the validation of encounter data submitted by Group or Participating Group Providers, Company will submit to Group and Participating Group Providers, as applicable, a copy of the Government Sponsor or CMS written notice of such review, along with a written request from Company for Audit Data.

### **3.0 COMPANY OBLIGATIONS**

3.1 Company's Covenants.

Company or Government Sponsors shall provide the following: a means for Members to identify themselves to Participating Group Providers (e.g., identification cards), an explanation of Group's payments, a general description of products, a listing of Participating Group Providers, and timely notification of Material Changes in this information. Company shall provide Group and Participating Group Providers with a means to check eligibility. Company shall include Group and Participating Group Providers in the participating provider directory or directories for the Plans, Specialty Programs and products in which Group's providers

are Participating Group Providers, including when Group and Participating Group Providers are designated as preferred participant, and shall make said directories available to Members. Company reserves the right to determine the content of Provider directories.

### 3.2 Company Representations.

Company represents and warrants that: (a) this Agreement has been executed by its duly authorized representative; and (b) executing this Agreement and performing its obligations hereunder shall not cause Company to violate any term or covenant of any other agreement or arrangement now existing or hereinafter executed.

The parties acknowledge that one or more state governmental authorities may recommend or require that various Company agreements, including this Agreement, be executed prior to the issuance to Company of one or more approvals, consents, licenses, permissions or other authorizations from governmental authorities with jurisdiction over the subject matter of this Agreement, or which Company deems to be necessary or desirable in its sole discretion (collectively, a "License"). Group agrees that all Company obligations to perform, and all rights of Group, under this Agreement are expressly conditioned upon the receipt of all Licenses. Failure of Company to obtain any License shall impose no liability on Company under this Agreement.

### 3.3 Company's Insurance.

Company at its sole cost and expense agrees to procure and maintain such policies of general and/or professional liability and other insurance (or maintain a self-insurance program) as shall be necessary to insure Company and its employees against any claim or claims for damages arising by reason of personal injuries or death occasioned directly or indirectly in connection with the performance of any service by Company under this Agreement and the administration of Plans.

## 4.0 **CLAIMS SUBMISSIONS, COMPENSATION AND MEMBER BILLING**

### 4.1 Claim Submission and Payment.

4.1.1 Obligation to Submit Claims. Group agrees to submit Clean Claims to Company for Provider Services rendered to Members by Participating Group Providers. Group agrees to submit claim and encounter data related to a Member enrolled in a Government Program in the form and manner as specified by Company and Group certifies that any such data is accurate, complete and truthful. Group and Participating Group Providers will make best commercial efforts to submit a minimum of eighty-five percent (85%) of its Member claims electronically to Company. Group and Participating Group Providers represent that, where necessary, they have obtained signed assignments of benefits authorizing payment for Providers Services to be made directly to Group. For claims Group submits electronically, Group shall not submit a claim to Company in paper form unless Company requests paper submissions or fails to pay or otherwise respond to electronic claims submission in accordance with the time frames required under this Agreement or applicable law or regulation. Group agrees that Company, or the applicable Government Sponsor, will not be obligated to make payments for billings received more than one hundred twenty (120) days (or such other period required by applicable state law or regulation) from (a) the date of service or, (b) the date of receipt of the primary payer's explanation of benefits when Company is the secondary payer. Company may waive this requirement if Group provides notice to Company, along with appropriate evidence, of other extraordinary circumstances outside the control of Group that resulted in the delayed submission. In addition, unless Group notifies Company of its payment disputes within one hundred eighty (180) days, or such other period as required by applicable state law or regulation, of receipt of payment from Company, such payment will be considered full and final payment for the related claims. If Group does not timely bill Company or Government Sponsors, or dispute any payment, timely as provided in this Section 4.1.1, Group's claim for payment will be deemed waived and Group will not seek payment from Government Sponsors, Company or Members. Group shall pay on a timely basis all Participating Group Providers, employees, independent contractors and subcontractors who render Covered Services to Members of Company's Plans for which Group is financially responsible pursuant to this Agreement.

Group agrees to permit claim editing to the primary procedure those services considered part of, incidental to, or inclusive of the primary procedure and to allow Company to make other adjustments for inappropriate billing or coding (e.g., rebundling, duplicative procedures or claim submissions, mutually exclusive procedures, gender/procedure mismatches, age/procedure mismatches). To the extent Group is billing on a CMS 1500 form, as of the Effective Date, in performing adjustments for inappropriate billing or coding, Company utilizes a commercial software package (as modified by Company for all Participating Group Providers in the ordinary course of Company's business) which commercial software package relies upon Government Programs and other industry standards in the development of its rebundling logic.

Subject to applicable law: (i) Company may update internal payment systems in response to additions, deletions, and changes to Government Sponsor, CMS, or other industry source codes without obtaining any consent from Group, Participating Group Providers, or any other party, and Company will provide, at the written request of Group, a copy of the fee schedule in effect at the time of such request; (ii) Company shall not be responsible for communicating such routine changes of this nature, and will update any applicable payment schedules on a prospective basis within ninety (90) days from the date of publication or such longer period as Company determines appropriate in its sole discretion; and (iii) Company shall have no obligation to retroactively adjust claims.

- 4.1.2 Company Obligation to Pay for Covered Services. Company shall make payments to Group for Covered Services on a timely basis consistent with the claims payment procedure described at 42 U.S.C. § 1396a(a)(37)(A). Company agrees to pay Group for non-capitated Covered Services rendered to Members according to the lesser of (i) Group's actual billed charges or (ii) the rates set forth in the **Services and Compensation Schedule**, attached hereto and made a part hereof. Company must pay ninety percent (90%) of all such Clean Claims from Group within thirty (30) days following actual receipt; provided, further, Company must pay ninety-nine percent (99%) of all Clean Claims from Group within ninety (90) days following actual receipt. Group and Participating Group Providers will make best commercial efforts to utilize online explanation of benefits or electronic remittance of advice (or combination thereof) and electronic funds transfer in lieu of receiving paper equivalents to the extent such services are available from Company. Company reserves the right to recoup any overpayment or payment made in error (e.g., a duplicate payment or payment for services rendered by Group to a patient who was not a Member and amounts identified through routine investigative reviews of records or audits) against any other monies due to Group under this Agreement.

In the event that Group identifies any overpayments by Company, Group shall, as required under Section 6402(a) of the Patient Protection and Affordable Care Act, report and return any and all such overpayments to Company within sixty (60) days of Group's identification of any and all such overpayments. In addition, when reporting and returning any such overpayments by Company, Group must provide Company with a written reason for the overpayment (e.g., excess payment under coordination of benefits, etc.).

To the extent, if any, that the compensation under certain Plans is in the form of capitation payments or a case-based rate methodology, Group acknowledges the financial risks to Group of this arrangement and has made an independent analysis of the adequacy of this arrangement. Group, therefore, agrees and covenants not to bring any action asserting the inadequacy of these arrangements or that Group was in any way improperly induced by Company to accept the rate of payment, including, but not limited to, causes of actions for damages, rescission or termination alleging fraud or negligent misrepresentation or improper inducement. Furthermore, to the extent that the compensation under certain Plans is in the form of capitation payments or a case-based methodology and Participating Group Provider utilizes the services of a Covering Provider, Group agrees to hold Company, Government Sponsor, Affiliates, and Members harmless against any and all claims by such Covering Provider related to or arising out of payment for Covered Services rendered to Members. Group understands that if Company makes payment to such Covering Provider under the circumstances described above, Company may recoup against future payments the amount paid to such Covering Provider.

Complaints or disputes concerning payments for the provision of services as described in this Agreement shall be subject to the Company's grievance resolution system.

- 4.1.3 Eligibility Determinations. Company shall have the right to recover payments made to Group if the payments are for services provided to an individual who is later determined to have been ineligible based upon information that is not available to Company at the time the service is rendered or authorization is provided.
- 4.1.4 Group's Payment to Participating Group Providers. Group shall be financially responsible for payment to all Participating Group Providers who render Covered Services to Members. Group shall require all Participating Group Providers who render such services to look solely to Group for payment. In addition, Group shall be financially responsible for payment to any other physicians who render Covered Services to Members when Group has been compensated on a capitated basis, if any, for such services. Group shall pay on a timely basis all Participating Group Providers and other physicians who render Covered Services for which Group is financially responsible hereunder. Company shall forward any claims it receives for payment for such services to Group. Company reserves the right to pay any Participating Group Provider or other provider for Covered Services for which Group is financially responsible and for which a valid, undisputed invoice, or portion thereof, is outstanding for more than fourteen (14) days beyond its due date, except that Company need not wait fourteen (14) days if Group has engaged in a pattern of late payments in the past. Company may deduct any such payments from any and all amounts due and payable to Group hereunder.
- 4.1.5 Utilization Management. Company utilizes systems of utilization review/quality improvement/peer review to promote adherence to accepted medical treatment standards and to encourage Participating Group Providers to minimize unnecessary medical costs consistent with sound medical judgment and in accordance with applicable law. To further this end, Participating Group Providers agree, consistent with sound medical judgment and in accordance with applicable law:
- (a) To participate, as requested, and to abide by Company's utilization review, patient management, quality improvement programs, and all other related programs (as modified from time to time) and decisions with respect to all Members.
  - (b) To comply with Company's pre-certification and utilization management requirements for all elective admissions and other Covered Services.
  - (c) To regularly interact and cooperate with Company's nurse case managers.
  - (d) To utilize Participating Group Providers to the fullest extent possible, consistent with sound medical judgment.
  - (e) To abide by all Company's credentialing criteria and procedures, including site visits and medical chart reviews, and to submit to these processes biannually, annually, or otherwise, when applicable.
  - (f) To obtain advance authorization from Company prior to any non-Emergency Service admission, and in cases where a Member requires an Emergency Service hospital admission or Post-stabilization Care Services, to notify Company, both in accordance with Company's Policies then in effect.

Except when a Member requires Emergency Services, Group and Participating Group Providers agree to comply with any applicable precertification and/or referral requirements under the Member's Plan prior to the provision of Provider Services. Group and Participating Group Providers agree to notify Company of all admissions of Members, and of all services for which Company requires notice, upon admission or prior to the provision of such services. For those Members who require services under a Specialty Program, Group and Participating Group Providers agree to work with Company in transferring the Member's care to a Specialty Program Provider.

#### 4.2 Coordination of Benefits.

Except as otherwise required under applicable Federal, state law or regulation or a Plan, when Company or a Government Sponsor is secondary payer under applicable coordination of benefit principles, and payment from the primary payer is less than the compensation payable under this Agreement without coordination of benefits, then Company or Government Sponsor will pay Group the lesser of (i) the copayment, coinsurance and deductible amount for the Covered Services as reported on the explanation of benefits of the primary payer, or (ii) the amount of the difference between the amount paid by the primary payer and the compensation payable under this Agreement, absent other sources of payment. Notwithstanding any other provision of this paragraph, if payment from the primary payer is greater than or equal to the compensation payable under this Agreement without coordination of benefits, neither Company, Government Sponsor nor the applicable Member (in accordance with Section 4.3.2 below) shall have any obligation to Group. Notwithstanding anything to the contrary in this section, in no event shall Group collect more than Medicare allows if Medicare is the primary payer. Medicaid is never the primary payer.

#### 4.3 Member Billing.

4.3.1 Permitted Billing of Members. Group may bill or charge Members only in the following circumstances: (a) applicable Copayments, Coinsurance and/or Deductibles, if any, not collected at the time that Covered Services are rendered; and (b) for services that are not Covered Services only if: (i) the Member's Plan provides and/or Company confirms that the specific services are not covered; (ii) the Member was advised in writing prior to the services being rendered that the specific services may not be Covered Services; and (iii) the Member agreed in writing to pay for such services after being so advised. Group acknowledges that Company's denial or adjustment of payment to Group based on Company's performance of utilization management as described in Section 4.1.5 or otherwise is not a denial of Covered Services under this Agreement or under the terms of a Plan, except if Company confirms otherwise under this Section 4.3.1. Group may bill or charge individuals who were not Members at the time that services were rendered.

4.3.2 Holding Members Harmless. Group and Participating Group Providers hereby agree that in no event, including, but not limited to the failure, denial or reduction of payment by Company, insolvency of Company or breach of this Agreement, shall Group or Participating Group Providers bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse (i) against Members or persons acting on their behalf (other than Company) or (ii) any settlement fund or other *res* controlled by or on behalf of, or for the benefit of, a Member for Covered Services. This provision shall not prohibit collection of Copayments, Coinsurance, or Deductibles made in accordance with the terms of the applicable Plan. Group and Participating Group Providers further agree that this Section 4.3.2: (a) shall survive the expiration or termination of this Agreement regardless of the cause giving rise to termination and shall be construed for the benefit of Members; and (b) supersedes any oral or written contrary agreement or waiver now existing or hereafter entered into between Group and Participating Group Providers and Members or persons acting on their behalf.

4.3.3 Dual Eligible Members. Group acknowledges and agrees that Members who are also enrolled in a State Medicaid plan ("Dual Eligible Members") are not responsible for paying to Group any Copayments, Coinsurance or Deductibles for Medicare Part A and Part B services ("Cost Sharing Amounts") when the State Medicaid plan is responsible for paying such Cost Sharing Amounts. Group further agrees that they will not collect Cost Sharing Amounts from Dual Eligible Members when the State is responsible for paying such Cost Sharing Amounts, and will, instead, either accept the Company's payment for Covered Services as payment in full for Covered Services and applicable Cost Sharing Amounts, or, bill the applicable State source for the appropriate Cost Sharing Amounts owed by the State Medicaid plan. Dual Eligible Members in Capitated Financial Alignment Demonstration Plans are not responsible for Cost Sharing Amounts for Medicare Parts A and B services.

To protect Members, Group agrees not to seek or accept or rely upon waivers of the Member protections provided by this Section 4.3.

## 5.0 COMPLIANCE WITH POLICIES

### 5.1 Policies.

Group and Participating Group Providers agree to accept and comply with Policies of which Group knows or reasonably should have known (e.g., Clinical Policy Bulletins or other Policies made available to Group and Participating Group Providers). Group and Participating Group Providers will utilize the electronic real time HIPAA compliant transactions, including but not limited to, eligibility, precertification and claim status inquiry transactions to the extent such electronic real time features are utilized by Company. Company may at any time modify Policies. Company will provide notice by letter, newsletter, electronic mail or other media, of Material Changes. Failure by Group to object in writing to any Material Change within thirty (30) days following receipt thereof constitutes Group's acceptance of such Material Change. In the event that Group reasonably believes that a Material Change is likely to have a material adverse financial impact upon Group's practice, Group agrees to notify Company in writing, specifying the specific bases demonstrating a likely material adverse financial impact, and the Parties will negotiate in good faith an appropriate amendment, if any, to this Agreement. Notwithstanding the foregoing, at Company's discretion, Company may modify the Policies to comply with applicable law or regulation, or any order or directive of any governmental agency, without the consent of Group, and the Policies shall be deemed to be automatically amended to conform with all laws and regulations promulgated at any time by any state or federal regulatory agency or authority having supervisory authority over this Agreement. Group and Participating Group Providers agree that noncompliance with any requirements of this Section 5.1 or any Policies will relieve Company or Government Sponsors and Members from any financial liability for the applicable portion of the Group Services.

### 5.2 Notices and Reporting.

To the extent neither prohibited by law nor violative of applicable privilege, Group and Participating Group Providers agree to provide notice to Company, and shall provide all information reasonably requested by Company regarding the nature, circumstances, and disposition, of: (a) any litigation or administrative action brought against Group and Participating Group Providers or any of its employees or affiliated providers which is related to the provision of health care services and could have a material impact on the Provider Services provided to Members; (b) Company requirements regarding reporting of self-referrals, loss of licensure or accreditation, and claims by governmental agencies or individual regarding fraud, abuse, self-referral, false claims, or kickbacks; and (c) any material change in services provided by Group and Participating Group Providers or licensure status related to such services. Company and Group agree to be mutually committed to promoting Member safety and quality. Therefore, Group will report the occurrence of and waive all charges related to those conditions specified under Section 5001(c) of the Deficit Reduction Act, Section 2702 of the Affordable Care Act and any related or similar federal or state regulation, in accordance with the terms thereof. Group agrees to use best efforts to provide Company with prior notice of, and in any event will provide notice as soon as reasonably practicable notice of, any actions taken by or against Group or Participating Group Providers described in this Section 5.2.

### 5.3 Information and Records.

5.3.1 Maintenance of Information and Records. Group and Participating Group Providers agree (a) to maintain Information and Records (as such terms are defined in Section 5.3.2) in a current, detailed, organized and comprehensive manner and in accordance with customary medical practice, Government Sponsor directives, applicable Federal and state laws, and accreditation standards; (b) that all Member medical records and Confidential Information shall be treated as confidential and in accordance with applicable laws; (c) to maintain such Information and Records for the longer of six (6) years after the last date Provider Services were provided to Member, or the period required by applicable law or Government Sponsor directives; and (d) to maintain Information and Records in accordance with the requirements of the compliance addenda. This Section 5.3.1 shall survive the termination of this Agreement, regardless of the cause of the termination.

5.3.2 Access to Information and Records. Group and Participating Group Providers agree that (a) Company (including Company's authorized designee) and Government Sponsors shall have access to all data and

information obtained, created or collected by Group and Participating Group Providers related to Members and necessary for payment of claims, including without limitation Confidential Information (“Information”); (b) Company (including Company’s authorized designee), Government Sponsors and Federal, state, and local governmental authorities and their agents having jurisdiction, upon request, shall have access to all books, records and other papers (including, but not limited to, contracts, medical and financial records and physician incentive plan information) and information relating to this Agreement and to those services rendered by Participating Group Providers to Members (“Records”); (c) consistent with the consents and authorizations required by Section 2.13 hereof, Company or its agents or designees shall have access to medical records for the purpose of assessing quality of care, conducting medical evaluations and audits, and performing utilization management functions; (d) applicable Federal and state authorities and their agents shall have access to medical records for assessing the quality of care or investigating Member grievances or complaints; and (e) Members shall have access to their health information as required by 45 C.F.R. § 164.524 and applicable state law, be provided with an accounting of disclosures of information when and as required by 45 C.F.R. § 164.528 and applicable state law, and have the opportunity to amend or correct the information as required by 45 C.F.R. § 164.526 and applicable state law. Group and Participating Group Provider agree to supply copies of Information and Records within fourteen (14) days of the receipt of a request, where practicable, and in no event later than the date required by Government Sponsor directives and any applicable law or regulatory authority. Subject to the provisions of this section as well as other provisions of this Agreement, Company confirms that, as between Company and Group and Participating Group Providers, Group and Participating Group Providers owns Group and Participating Group Providers’ medical records. This Section 5.3.2 shall survive the termination of this Agreement, regardless of the cause of termination.

5.3.3 Government Requirements Regarding Records for Medicare Members. In addition to the requirements of Sections 5.3.1 and 5.3.2, with respect to Medicare Plans, Group agrees to maintain Information and Records (as those terms are defined in Section 5.3.2) for the longer of: (i) ten (10) years from the end of the final contract period of any government contract of Company, (ii) the date the U.S. Department of Health and Human Services (“HHS”), the U.S. Comptroller General, or their designees complete an audit, or (iii) the period required by applicable laws, rules or regulations. Group further agrees that, with respect to Medicare Plans, Company and Federal, state and local government authorities having jurisdiction, or their designees, upon request, shall have access to all Information and Records, and that this right of inspection, evaluation and audit of Information and Records shall continue for the longer of (i) ten (10) years from the end of the final contract period of any government contract of Company, (ii) the date HHS, the U.S. Comptroller General, or their designee complete an audit, or (iii) the period required by applicable laws, rules or regulations. This Section 5.3.3 shall survive the termination of this Agreement, regardless of the cause of termination.

5.4 Quality, Accreditation and Review Activities.

Group and Participating Group Providers agree to cooperate with any Company quality activities or review of Company or a Plan conducted by the National Committee for Quality Assurance (NCQA) or a Federal or state agency with authority over Company and/or the Plan, as applicable.

5.5 Proprietary Information.

5.5.1 Rights and Responsibilities. Each Party agrees that the Proprietary Information of the other Party is the exclusive property of such Party and that each Party has no right, title or interest in the same. Each Party agrees to keep the Proprietary Information and this Agreement strictly confidential and agrees not to disclose any Proprietary Information or the contents of this Agreement to any third party without the other Party’s consent, except (i) to governmental authorities having jurisdiction, (ii) in the case of Company’s disclosure to Members, Government Sponsors, consultants or vendors under contract with Company, and (iii) in the case of Participating Group Providers’ disclosure to Members for the limited purpose of advising Members of potential treatment options and costs consistent with applicable Federal and state laws. Except as otherwise required under applicable Federal or state law, each Party agrees to not use any Proprietary Information of the other Party, and at the request of the other Party hereto, return any Proprietary Information upon termination of this Agreement for whatever reason.

Notwithstanding the foregoing, Participating Group Providers are encouraged to discuss Company's provider payment methodology with patients, including descriptions of the methodology under which the Group or Participating Group Providers are paid. In addition, Participating Group Providers may freely communicate with patients about their treatment options, regardless of benefit coverage limitations. This Section 5.5.1 shall survive the termination of this Agreement for one (1) year, regardless of the cause of termination.

## **6.0 TERM AND TERMINATION**

### **6.1 Term.**

This Agreement shall be effective for an initial term ("Initial Term") of one (1) year from the Effective Date, and thereafter shall automatically renew for additional terms of one (1) year each, unless and until terminated in accordance with this Article 6.0.

### **6.2 Termination without Cause.**

This Agreement may be terminated by Company at any time without cause with at least sixty (60) days prior written notice to Group. This Agreement may be terminated by Group without cause at any time following the conclusion of the Initial Term with at least sixty (60) days prior written notice to Company.

### **6.3 Termination for Breach.**

This Agreement may be terminated at any time by either Party upon at least sixty (60) days prior written notice of such termination to the other Party upon material default or substantial breach by such Party of one or more of its obligations hereunder, unless such material default or substantial breach is cured within thirty (30) days of the notice of termination; provided, however, if such material default or substantial breach is incapable of being cured within such thirty (30) day period, any termination pursuant to this Section 6.3 will be ineffective for the period reasonably necessary to cure such breach if the breaching party has taken all steps reasonably capable of being performed within such thirty (30) day period. Furthermore, Company may terminate the status of any Participating Group Provider for default or breach of said Participating Group Provider's obligations hereunder upon at least thirty (30) days notice to said Participating Group Provider, unless such default or breach is cured within the notice period. Notwithstanding the foregoing, the effective date of such termination may be extended pursuant to Section 6.6 herein.

### **6.4 Immediate Termination or Suspension.**

Company may immediately terminate this Agreement or, where applicable, the status of any Participating Group Provider, at Company's discretion at any time, due to any of the following events: (a) the suspension, withdrawal, expiration, revocation or non-renewal of any Federal, state or local license, certificate or other legal credential authorizing Group and/or Participating Group Providers to practice medicine; (b) a suspension or revocation of a Participating Group Provider's DEA certification or other right to prescribe controlled substances; (c) an indictment, arrest or conviction of a felony or for any criminal charge related to or in any way impairing Group's and Participating Group Provider's practice of medicine; (d) the loss or material limitation of Group's or Participating Group Provider's insurance under Section 2.11 of this Agreement; (e) the exclusion, debarment or suspension of Group and/or any Participating Group Provider from participation in any governmental sponsored program, including, but not limited to, Government Programs, Medicare or the Medicaid program in any state; (f) the listing of Group or Participating Group Providers in the HIPDB; (g) change of control of Group to an entity not acceptable to Company; (h) any false statement or material omission of Participating Group Provider in the participation application and/or confidential information forms and all other requested information, as determined by Company in its sole discretion; (i) any adverse action with respect to Participating Group Provider's hospital staff privileges; (j) a determination by Company that Group or Participating Group Provider's continued participation in provider networks could result in harm to Members; or (k) the withdrawal, expiration or termination of the State Contract. To protect the interests of patients, including Members, Group and/or Participating Group Providers will provide immediate notice to Company of any of the aforesaid events described in clauses (a) through (j), including notification of impending bankruptcy.

6.5 Obligations Following Termination.

Following the effective date of any expiration or termination of this Agreement or any Plan, Group and Participating Group Providers and Company will cooperate as provided in this Section 6.5 and in the compliance addenda. This Section 6.5 and the compliance addenda, shall survive the termination of this Agreement, regardless of the cause of termination.

6.5.1 Upon Termination. Upon expiration or termination of this Agreement for any reason, other than termination by Company in accordance with Section 6.4 above, Group and Participating Group Providers agree to provide Provider Services at Company's discretion to: (a) any Member under a Participating Group Provider's care who, at the time of the expiration or termination is a registered bed patient at a Participating Facility until such Member's discharge or Company's orderly transition of such Member's care to another provider; and (b) any Member, upon request of such Member or the applicable Plan Sponsor, for one (1) calendar year. The terms of this Agreement, including the **Services and Compensation Schedule** shall apply to all services under this Section 6.5.1.

6.5.2 Upon Insolvency or Cessation of Operations. If this Agreement terminates as a result of insolvency or cessation of operations of Company, and as to Members of HMOs that become insolvent or cease operations, then in addition to other obligations set forth in this section, Group and Participating Group Providers shall continue to provide Provider Services to: (a) all Members for the period for which premium has been paid; and (b) Members confined in an inpatient facility on the date of insolvency or other cessation of operations until medically appropriate discharge. This provision shall be construed to be for the benefit of Members. No modification of this provision shall be effective without the prior written approval of the applicable regulatory agencies.

6.5.3 Obligation to Cooperate. Upon notice of expiration or termination of this Agreement or of a Plan, Group and Participating Group Providers shall cooperate with Company and comply with Policies in the transfer of Members to other providers.

6.5.4 Obligation to Notify Members. Upon notice of termination of this Agreement or of a Plan, Company shall provide reasonable advance notice of the impending termination to Members of Plans currently under the treatment of Group and/or Participating Group Provider, or in the event of immediate termination, as soon as practicable after termination.

6.6 Obligations During Dispute Resolution Proceedings.

In the event of any dispute between the Parties in which a Party has provided notice of termination under Section 6.3 and the dispute is required to be resolved or is submitted for resolution under Article 8.0 below, the termination of this Agreement shall be stayed and the Parties shall continue to perform under the terms of this Agreement until the final resolution of the dispute.

**7.0 RELATIONSHIP OF THE PARTIES**

7.1 Independent Contractor Status.

The relationship between Company and Group, as well as their respective employees and agents, is that of independent contractors, and neither shall be considered an agent or representative of the other Party for any purpose, nor shall either hold itself out to be an agent or representative of the other for any purpose. Company and Group will each be solely liable for its own activities and those of its agents and employees, and neither Company nor Group will be liable in any way for the activities of the other Party or the other Party's agents or employees arising out of or in connection with: (a) any failure to perform any of the agreements, terms, covenants or conditions of this Agreement; (b) any negligent act or omission or other misconduct; (c) the failure to comply with any applicable laws, rules or regulations; or (d) any accident, injury or damage. Group and Participating Group Providers acknowledge that all Member care and related decisions are the responsibility of Participating Group Providers and that Policies do not dictate or control a Participating Group Providers' clinical decisions with respect to the care of Members. Group agrees to indemnify and hold harmless the Government Sponsor and Company from any and all claims, liabilities and third party causes of action arising out of the Participating Group Providers' provision of care to Members. Company agrees to indemnify and hold harmless the Group from any and all claims, liabilities and third party

causes of action arising out of the Company's administration of health care services in connection with the Plans. This provision shall survive the expiration or termination of this Agreement, regardless of the reason for termination.

7.2 Use of Name.

Group and Participating Group Providers consent to the use of Group and Participating Group Providers' names and other identifying and descriptive material in provider directories and in other materials and marketing literature of Company in all formats, including, but not limited to, electronic media. Group and Participating Group Providers may use Company's names, logos, trademarks or service marks in marketing materials or otherwise, upon receipt of Company's prior written consent, which shall not be unreasonably withheld.

7.3 Interference with Contractual Relations.

Group and Participating Group Providers shall not engage in activities that will cause Company to lose existing or potential Members, including but not limited to: (a) advising Company customers, Government Sponsors or other entities currently under contract with Company to cancel, or not renew said contracts; (b) impeding or otherwise interfering with negotiations which Company is conducting for the provision of health benefits or Plans; or (c) using or disclosing to any third party membership lists acquired during the term of this Agreement for the purpose of soliciting individuals who were or are Members or otherwise to compete with Company. Notwithstanding the foregoing, Company shall not prohibit, or otherwise restrict, Participating Group Providers from advising or advocating on behalf of a Member who is his or her patient, for the following: (i) the Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered; (ii) any information the Member needs in order to decide among all relevant treatment options; (iii) the risks, benefits, and consequences of treatment or nontreatment; and (iv) the Member'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. This section shall continue to be in effect for a period of one (1) year after the expiration or termination of this Agreement.

## 8.0 DISPUTE RESOLUTION

8.1 Member Grievance Dispute Resolution.

Group and Participating Group Providers agree to (a) cooperate with and participate in Company's applicable appeal, grievance and external review procedures (including, but not limited to, Medicaid appeals and expedited appeals procedures), (b) provide Company with the information necessary to resolve same, and (c) abide by decisions of the applicable appeals, grievance and review committees. Company will make available to Group and Participating Group Providers information concerning the Member appeal, grievance and external review procedures at the time of entering into this Agreement.

8.2 Provider Dispute Resolution.

Company shall provide a mechanism whereby Group may raise issues, concerns, controversies or claims regarding the obligations of the Parties under this Agreement. Group shall exhaust this mechanism prior to instituting any arbitration or other permitted legal proceeding. The Parties agree that any dispute that may arise between the Parties shall not disrupt or interfere with the provision of services to Members. Discussions and negotiations held pursuant to this Section 8.2 shall be treated as inadmissible compromise and settlement negotiations for purposes of applicable rules of evidence.

8.3 Arbitration.

Any controversy or claim arising out of or relating to this Agreement including breach, termination, or validity of this Agreement, except for temporary, preliminary, or permanent injunctive relief or any other form of equitable relief, shall be settled by binding arbitration. The arbitration will be administered by the American Arbitration Association ("AAA") or the Judicial Arbitration and Mediation Services ("JAMS") and conducted by a sole Arbitrator. If a party believes that the arbitrator has committed an error of law or legal reasoning, the party can appeal to a court of competent jurisdiction to correct any such error of law or legal reasoning. Depositions for discovery purposes shall not be permitted. The arbitrator may award only monetary damages in accordance with this Agreement.

8.4 Arbitration Solely Between Parties; No Consolidation or Class Action.

Any arbitration or other proceeding related to a dispute arising under this Agreement shall be conducted solely between them. Neither Party shall request, nor consent to any request, that their dispute be joined or consolidated for any purpose, including without limitation any class action or similar procedural device, with any other proceeding between such Party and any third party.

**9.0 MISCELLANEOUS**

9.1 Amendments.

This Agreement constitutes the entire understanding of the Parties specifically pertaining to those publicly funded managed care programs for Medicaid, CHIP or other low-income individuals offered by Company within the State of Virginia. This Agreement shall supersede any prior agreements with Company or MHNet to the extent such agreements apply to, or include, such programs. No changes, amendments or alterations to this Agreement shall be effective unless signed by both Parties, except as expressly provided herein. Company may amend this Agreement upon thirty (30) days prior written notice, by letter, newsletter, electronic mail or other media (an "Amendment"). Failure by Group to object in writing to any such Amendment within thirty (30) days following receipt thereof constitutes Group's acceptance of such Amendment. In the event that Group reasonably believes that an Amendment is likely to have a material adverse impact upon Group, Group agrees to notify Company in writing, specifying the specific bases demonstrating a likely material adverse impact, and the Parties will negotiate in good faith an appropriate revised Amendment, if any, to this Agreement. Notwithstanding the foregoing, at Company's discretion, Company may amend this Agreement to comply with applicable law or regulation, or any order or directive of any governmental agency, without the consent of Group, and this Agreement shall be deemed to be automatically amended to conform with all laws and regulations promulgated at any time by any state or federal regulatory agency or authority having supervisory authority over this Agreement. Group and Participating Group Providers agree that noncompliance with any requirements of this Section 9.1 will relieve Company or Government Sponsors and Members from any financial liability for the applicable portion of the Provider Services. Changes to Policies are addressed by Section 5.1 hereto.

9.2 Waiver.

The waiver by either Party of a breach or violation of any provision of this Agreement shall not operate as or be construed to be a waiver of any subsequent breach thereof. To be effective, all waivers must be in writing and signed by an authorized officer of the Party to be charged. Group waives any claims or cause of action for fraud in the inducement or execution related hereto.

9.3 Governing Law.

This Agreement and the rights and obligations of the parties hereunder shall be construed, interpreted, and enforced in accordance with, and governed by, the laws of the State of Virginia.

9.4 Liability.

Notwithstanding Section 9.3, either Party's liability, if any, for damages to the other Party for any cause whatsoever arising out of or related to this Agreement, and regardless of the form of the action, shall be limited to the damaged Party's actual damages. Neither Party shall be liable for any indirect, incidental, punitive, exemplary, special or consequential damages of any kind whatsoever sustained as a result of a breach of this Agreement or any action, inaction, alleged tortious conduct, or delay by the other Party.

9.5 Severability.

Any determination that any provision of this Agreement or any application thereof is invalid, illegal or unenforceable in any respect in any instance shall not affect the validity, legality and enforceability of such provision in any other instance, or the validity, legality or enforceability of any other provision of this Agreement. Neither Party shall assert or claim that this Agreement or any provision hereof is void or voidable if such Party performs under this Agreement without prompt and timely written objection.

9.6 Successors; Assignment.

This Agreement relates solely to the provision of Provider Services by Group and Participating Group Providers and does not apply to any other organization which succeeds to Group assets, by merger,

acquisition or otherwise, or is an affiliate of Group. Neither Party may assign its rights or its duties and obligations under this Agreement without the prior written consent of the other Party, which consent may not be unreasonably withheld; provided, however, that Company may assign its rights or its duties and obligations to an Affiliate or successor in interest so long as any such assignment or delegation will not have a material impact upon the rights, duties and obligations of Group.

9.7 Headings.

The headings contained in this Agreement are included for purposes of convenience only, and shall not affect in any way the meaning or interpretation of any of the terms or provisions of this Agreement.

9.8 Notices.

Except for any notice required under Article 6, Term and Termination, or if otherwise specified, notices required pursuant to the terms and provisions hereof may be effective if sent by letter, electronic mail or other generally accepted media. With respect to notices required under Article 6, notice shall be effective only if given in writing and sent by overnight delivery service with proof of receipt, or by certified mail return receipt requested. Notices shall be sent to the addresses set forth on the signature page of this Agreement (which addresses may be changed by giving notice in conformity with this Section 9.8). Provider shall notify Company of any changes in the information provided by Provider related to Provider's address.

9.9 Remedies.

Notwithstanding Sections 8.3 and 9.4, the Parties agree that each has the right to seek any and all remedies at law or equity in the event of breach or threatened breach of Section(s) 5.5, 6.6 and 7.3.

9.10 Force Majeure.

If either Party shall be delayed or interrupted in the performance or completion of its obligations hereunder by any act, neglect or default of the other Party, or by an embargo, war, act of terror, riot, incendiary, fire, flood, earthquake, epidemic or other calamity, act of God or of the public enemy, governmental act (including, but not restricted to, any government priority, preference, requisition, allocation, interference, restraint or seizure, or the necessity of complying with any governmental order, directive, ruling or request) then the time of completion specified herein shall be extended for a period equivalent to the time lost as a result thereof. This Section 9.10 shall not apply to either Party's obligations to pay any amounts owing to the other Party, nor to any strike or labor dispute involving such Party or the other Party.

9.11 Non-Exclusivity.

This Agreement is not exclusive, and nothing herein shall preclude either Party from contracting with any other person or entity for any purpose. Company makes no representation or guarantee as to the number of Members who may select or be assigned to Group and Participating Group Providers.

9.12 Confidentiality.

It is further understood and agreed by and among the Parties that the terms and conditions of this Agreement, except as otherwise specified, are and shall remain confidential, and shall not be disclosed by either Party without express written consent of the other Party or as required by law or by governmental authorities or by express order by a court having jurisdiction over the Party from whom disclosure is sought.

9.13 Entire Agreement.

This Agreement (including any attached schedules, appendices and/or addenda) constitutes the complete and sole contract between the Parties regarding the subject matter described above and supersedes any and all prior or contemporaneous oral or written representations, communications, proposals or agreements not expressly included in this Agreement and may not be contradicted or varied by evidence of prior, contemporaneous or subsequent oral representations, communications, proposals, agreements, prior course of dealings or discussions of the Parties. The Parties understand and agree that this Agreement only applies to the Plans described in this Agreement and, likewise, this Agreement does not and will not supersede any agreement(s) between Company's affiliates and Provider that relates to Company's affiliates other lines of business that are not the subject of this Agreement (that are not the Plans described in this Agreement).

- 9.14 Signatures. Facsimile and electronic signatures shall be deemed to be original signatures for all purposes of this Agreement.
- 9.15 Incorporation of Recitals. The Parties incorporate the recitals into this Agreement as representations of fact to each other.

*\*\*Remainder of page intentionally left blank. Signature page follows.\*\**

**IN WITNESS WHEREOF**, the undersigned parties have executed this Agreement by their duly authorized officers, intending to be legally bound hereby.



**GROUP**

By: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

**COMPANY**

By: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

**REIMBURSEMENT ADDRESS:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MAIN TELEPHONE NUMBER:** \_\_\_\_\_

**CHIEF EXECUTIVE OFFICER:** \_\_\_\_\_

**CHIEF FINANCIAL OFFICER:** \_\_\_\_\_

**BUSINESS OFFICE MANAGER:** \_\_\_\_\_

**FEDERAL TAX I.D. NUMBER:** \_\_\_\_\_

**NPI NUMBER:** \_\_\_\_\_

**As required by Section 9.8 (“Notices”) of this Agreement, notices shall be sent to each Party at the following addresses:**

To Group at:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

To Company at:

Coventry Health Care of Virginia, Inc.  
Attn: Network Management  
9881 Mayland Drive  
Richmond, VA 23233

With a copy to:

Aetna  
Law Dept, Medicaid, Mail Code RE6A  
151 Farmington Avenue  
Hartford, CT 06156-0001

## **PROGRAM PARTICIPATION SCHEDULE**

Group agrees to participate in the Plans and other health benefit programs listed herein:

Those publicly funded managed care programs for Medicaid, CHIP or other low-income individuals offered by Company within the State of Virginia.

Those Medicare plans for Medicaid enrollees offered by Company within the State of Virginia. Includes Medicare D-SNP and integrated Medicare-Medicaid Plans.

Those Qualified Health Plans, whether purchased on the exchange or in the private market, offered by Company within the State of Virginia.

## SERVICES AND COMPENSATION SCHEDULE

### 1.0 COMPENSATION

Virginia Medicaid, CHIP & QHP Plans:	100%	Aetna Medicaid Market Fee Schedule
Virginia Medicare Plans:	100%	Medicare Allowable Rate

### 2.0 SERVICES

Provider will be reimbursed for those Covered Services in accordance with the terms of this Agreement that are within the scope of and appropriate to the Provider's license and certification to practice.

### 3.0 GENERAL COMPENSATION TERMS AND CONDITIONS

#### Definitions

"Aetna Medicaid Market Fee Schedule (AMMFS)" – A fee schedule that is based upon the contracted location where service is performed and the State of Virginia Medicaid Fee Schedule.

"Medicare Allowable" - the current payment as of discharge date that a hospital will receive from Company, subject to the then current Medicare Inpatient Prospective Payments Systems and will be updated in accordance with CMS changes, provided, however, that exempt units for psychiatric, rehabilitation and skilled nursing facility services will be paid in accordance with the applicable Medicare Prospective Payment Systems. These payments are intended to mirror the payment a Medicare Fiscal Intermediary ("FI") would make to the hospital, less (with respect to DRG-based payments) the payments for Indirect Medical Education (IME), Direct Graduate Medical Education (DGME), bad debt, as appropriate and adjusted by CMS or Government Sponsor for sequestration, SGR or other items and Aetna payment and processing guidelines. For other provider types, the Medicare allowable rate is based upon CMS Geographic Pricing Cost Indices (GPCI) and Resource Based Relative Value Scale (RBRVS) Relative Value Units (RVU) including Outpatient Prospective Payment System (OPPS) cap rates; the Clinical Laboratory Fee Schedule (CLAB); the Durable Medical Equipment, Prosthetics, Orthotics and Supplies Fee Schedule; including PEN (DMEPOS) and 'Medicare Part B Drug Average Sales Price (ASP),' as appropriate. Coding and fees determined under this schedule will be updated as CMS releases code updates, changes in the MFS relative values, including OPPS cap payments, or the CMS conversion factors. Company plans to update the schedule within 90 days of the final rates and/or codes being published by CMS. However, the rates and coding sets for these services do not become effective until updates are completed by Company and payment is considered final and exclusive of any retroactive or retrospective CMS adjustments to the rate. Company payment policies apply to services paid based upon the Medicare allowable rate.

#### General

- A. Member Cost Share. Rates are inclusive of any applicable Member Copayment, Coinsurance or Deductible.
- B. Billing. When billing, Provider must designate applicable codes related to those Covered Services provided by Provider under the terms of this Agreement.
- C. Coding. Company utilizes nationally recognized coding structures including, but not limited to, Revenue Codes as described by the Uniform Billing Code, AMA Current Procedural Terminology (CPT4), CMS Common Procedure Coding System (HCPCS), Diagnosis Related Groups (DRG), ICD-10 Diagnosis and Procedure codes or any successor thereto, and National Drug Codes (NDC). As changes are made to nationally-recognized codes, Company will update internal systems to accommodate new codes. Such changes will only be made when there is no material change in the procedure itself. Until updates are complete, the procedure will be paid according to the standards and coding set for the prior period. Company will comply and utilize nationally recognized coding

structures as directed under applicable Federal laws and regulations, including, without limitation, the Health Insurance Portability and Accountability Act (HIPAA).

D. Affordable Care Act Primary Care Enhancement. For those primary care Covered Services that the State of Virginia has determined to reimburse at 100% of the Medicare allowable amount in accordance with Section 1902(a)(13)(C) of the Social Security Act, for so long as the rates are in effect and so long as the Participating Group Provider meets the requirements of applicable law for the rates, Company shall compensate Group for the provision of such Covered Services to eligible Members delivered in accordance with the terms and conditions set forth in this Agreement at the lesser of Group's billed charges or an amount equal to but not greater than the State's enhanced rates. Group certifies that, to the extent required by law, such payments will inure to the benefit of the individual Participating Physicians, and will supply Company with any legally-required documentation of such. Company reserves the right i) to pay such enhanced compensation through monthly or quarterly adjustment; ii) to make payments directly to qualifying Participating Physicians; and/or iii) to require such Physicians or Group to complete any agreements, forms, attestations or releases needed to effectuate such payments. Enhanced compensation is not available for Members of CHIP Plans.

E. Medicare-Medicaid Dual-Eligibles. Where Company is the responsible payor for Medicare and Medicaid Covered Services, rates for each service are determined by whether that service is regarded as a Medicare Covered Service or a Medicaid Covered Service by CMS and Government Sponsor, and with respect to a Member's benefit limits under each program. For Medicare Covered Services (inclusive of Member Copayment or Coinsurance), Company shall compensate provider at the specified Medicare rate. For Medicaid Covered Services, Company shall compensate provider according to the applicable Medicaid rate. When a service is covered under Medicare and Medicaid, Company will determine the rate (Medicare or Medicaid) according to applicable law, coordination of benefit principles and the terms of Member's Plan. Rates do not include, and Company is not responsible for, supplemental or wrap-around payments unless required by Company's contracts with Government Sponsor.

*\*\*Remainder of page intentionally left blank.\*\**

**INDIVIDUAL PROVIDER ADDENDUM**

The undersigned provider (“Provider”), an employee, partner, shareholder or contractor of [ \_\_\_\_\_ ] (“Group”), acknowledges and represents that Group is his/her attorney-in-fact for the purposes of negotiating, consenting to and executing the Provider Group Agreement (the “Agreement”), between Company and Group and any documents related to amendments to the Agreement. Terms capitalized herein but not otherwise defined shall have the meanings ascribed to them in the Agreement.

Provider hereby acknowledges that Provider has had the opportunity to review the Agreement, under which Group, on behalf of Provider, agrees to participate in Company’s provider networks and provide Covered Services to Members enrolled in the Plans. Provider hereby agrees to be bound by the terms and conditions of the Agreement, including, without limitation, compliance with the participation criteria set forth in the **Participation Criteria Schedule** as applicable to Provider and all applicable Company Policies.

Provider hereby agrees that in the event: (i) Provider ceases to be a member of Group; (ii) the Agreement expires or is terminated for any reason; (iii) Group is dissolved; (iv) a voluntary or involuntary bankruptcy or a proposed settlement of outstanding debts under applicable reorganization or insolvency laws is filed by or against Group, a receiver is appointed or Group makes an assignment for the benefit of creditors; or (v) Group otherwise ceases to exist, either voluntarily or involuntarily, the terms of the Agreement shall, at Company’s option, survive with respect to Provider for the first six (6) months after such event (“Continuation Period”), in which case Provider shall continue to provide services to Members in accordance with the terms of the Agreement during the Continuation Period and compensation during the Continuation Period shall be at the rate set forth in the Agreement.

With the exception of services provided to Members during the Continuation Period (when Provider will bill Company directly), Provider hereby agrees to seek compensation solely from Group for services rendered to Members under the terms of the Agreement, and shall in no event bill Company, Government Sponsor or Members for any such services (except for any Copayments, Coinsurance or Deductibles, if any, that Members may be required to pay for certain Covered Services). Provider further agrees that in no event, including but not limited to non-payment by Company, insolvency of the Company or breach by Company of the Agreement, shall Provider bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against a Member or persons acting on Member’s behalf for Covered Services. This provision shall not prohibit collection of Copayments, Coinsurance or Deductibles, if any, as set forth in the Agreement. Provider further agrees that this provision shall be construed for the benefit of Members, shall supersede any oral or written agreement to the contrary now existing or hereafter entered into between Provider or Group and a Member or any person acting on behalf of a Member, and shall survive the termination of the Agreement, regardless of the cause giving rise to termination.

Company, Group and Provider desire to promote continuity of care. Accordingly, upon expiration or termination of the Continuation Period for any reason, Provider agrees to provide Provider Services pursuant to the terms of the Agreement, including the compensation terms, at Company’s discretion to: (a) any Member under a Provider’s care who, at the time of the expiration or termination is a registered bed patient at a Participating Facility until such Member’s discharge or Company’s orderly transition of such Member’s care to another provider; and (b) any Member, upon request of such Member or the applicable Government Sponsor for one (1) calendar year.

In the event Group is dissolved or otherwise ceases to exist, Provider shall be bound by the terms of this Individual Provider Addendum, and shall be compensated for Covered Services according to the terms and conditions set forth in the Agreement.

IN WITNESS WHEREOF, the undersigned has executed this Individual Provider Addendum as of this \_\_\_\_ day of \_\_\_\_\_, 20 \_\_, intending to be legally bound hereby.

PROVIDER: \_\_\_\_\_  
PRINTED NAME: \_\_\_\_\_  
NPI NUMBER: \_\_\_\_\_

## ADDENDUM A

### VIRGINIA MEDICAID COMPLIANCE ADDENDUM – PROVIDER

This Medicaid Compliance Addendum is incorporated by reference in the Agreement. If there is any conflict between the terms of this Addendum and any of the terms of the Agreement, including any attachments, schedules, exhibits and/or addenda made part of the Agreement, the terms of this Addendum shall govern and control; provided, however, that if there is any conflict between any of the terms of the Agreement, including this Addendum, and the applicable State Contract, then the terms of the applicable State Contract will govern and control.

For purposes of this Addendum, the term “Provider” shall mean the health care provider, or physician, group, facility or hospital executing the Agreement, as identified on the first page of the Agreement. In the event that any of the following required Medicaid provisions are inapplicable to Provider, as construed under the applicable State Contract and in accordance with Applicable Law, such provision shall not apply.

Company and Provider agree to abide by all applicable provisions of the applicable State Contract. Provider compliance with the applicable State Contract specifically includes, but is not limited to, the requirements contained herein.

#### 1.0 DEFINITIONS

All capitalized terms used in this Addendum, and not otherwise defined in this Addendum, shall have the meanings set forth in the Agreement, or if not defined in the Agreement, in the applicable State Contract.

1.1 Applicable Law. All federal or state laws, rules, regulations, and administrative agency directives applicable to the Medicaid program and to Medicaid managed care plans, as these may be amended from time to time, including, but not limited to, statutes and regulations related to fraud, abuse, discrimination, disabilities, confidentiality, self-referral, false claims and prohibition of kickbacks. Applicable Laws include the Centers for Medicare and Medicaid Services’ (“CMS”) and the Virginia Department of Medical Assistance Services’ (“DMAS” or the “Department”) instructions, policy letters or guidelines that regulate the actions of Provider or Company, requirements of the State Plan, as applicable, and requirements of the applicable State Contract. The “State Plan” is the State Plan for Medical Assistance, submitted to CMS by DMAS describing the nature and scope of the Virginia Medicaid program. DMAS has the authority to administer the State Plan under Code of Virginia § 32.1-325. The words “applicable law,” as they appear in the Agreement, shall have the same meaning as given to “Applicable Law” herein.

1.2 Medically Necessary or Medical Necessity. Appropriate and necessary health care services which are rendered for any condition which, according to generally accepted principles of good medical practice, requires the diagnosis or direct care and treatment of an illness, injury, or pregnancy-related condition, and are not provided only as a convenience. As defined in 42 CFR § 440.230, services must be sufficient in amount, duration and scope to reasonably achieve their purpose. For children under age 21, medical necessity review must fully consider Federal EPSDT guidelines for Medallion 3.0 enrollees. EPSDT is not applicable to FAMIS. (*Medallion 3.0 Contract, Section 1.1; FAMIS Contract, Section 1.1*)

#### 2.0 REGULATORY AND CONTRACTUAL REQUIREMENTS FOR MEDALLION 3.0, FAMIS, MLTSS

The following provisions are applicable to Provider to the extent that the citation following the provision references (i) a regulation of general applicability or (ii) the State Contract under which Provider provides services to Company in accordance with the Agreement.

2.1 Duty to Refund. Provider shall be required to refund payments made by DMAS if Provider is found to have billed DMAS contrary to policy, failed to maintain records or adequate documentation to support its claims, or billed for medically unnecessary services. (*12VAC30-120-1720(A)(4); 12VAC30-141-650(D); and 12VAC30-141-870(D)*)

2.2 Provider Agreement Subject to Department Review. Provider acknowledges and agrees that the Department may approve, modify and approve, or deny the Agreement and any changes in approved agreements at its sole discretion. Provider further acknowledges and agrees that the Department, at its sole discretion, may impose such conditions or limitations on its approval of the Agreement or changes to approved agreements as it deems appropriate. Provider shall cooperate with Company in Company's submission to the Department of the Agreement for initial approval and, if necessary, approval of any future changes. (*Medallion 3.0 Contract, Attachment III; FAMIS Contract, Attachment III; CCC Plus Contract, Section 8.5*)

2.3 Validity of Terms. No terms of the Agreement are valid which terminate legal liability of Company in the applicable State Contract. (*Medallion 3.0 Contract, Attachment III; FAMIS Contract, Attachment III, Section A.1; CCC Plus Contract, Section 8.5.3*)

2.4 Provider Cooperation with Company Programs. Provider agrees to participate in and contribute required data to Company's quality improvement and other assurance programs as required in the applicable State Contract. Provider agrees to cooperate with the External Quality Review Organization (EQRO), which is contracted by the Department to perform quality studies. The level of cooperation includes, but is not limited to, responding favorably and promptly to requests for Members' medical records in the format and timeframe requested by the EQRO or the Department. (*Medallion 3.0 Contract, Section 8.4 and Attachment III; FAMIS Contract, Section 8.4 and Attachment III, Section A.2*)

2.5 Emergency and Urgent Care. Provider agrees to abide by the terms of the applicable State Contract for the timely provision of emergency and urgent care. Where applicable, Provider agrees to follow those procedures for handling urgent and emergency care cases stipulated in any required hospital/emergency department Memorandums of Understanding signed by Company in accordance with the applicable State Contract. (*Medallion 3.0 Contract, Attachment III; FAMIS Contract, Attachment III, Section A.3*)

2.6 Utilization Data. Provider agrees to submit to Company utilization data in the format specified by Company, so Company can meet the Department specifications required by the applicable State Contract. (*Medallion 3.0 Contract, Attachment III; FAMIS Contract, Attachment III, Section A.4; CCC Plus Contract, Section 8.5.4.1*)

2.7 Conflicts. Any conflict in the interpretation of Company's Policies and MCO-Network Provider contract shall be resolved in accordance with Federal and Virginia laws and regulations, including the State Plan for Medical Assistance Services and Department memos, notices and provider manuals. (*Medallion 3.0 Contract, Attachment III; FAMIS Contract, Attachment III, Section A.5; CCC Plus Contract, Section 8.5.4.1*)

2.8 Non-discrimination. Provider agrees to comply with all non-discrimination requirements in the applicable State Contract. For example, but not by way of limitation, Provider shall offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid fee-for-service, if Provider serves only Medicaid members. (*Medallion 3.0 Contract, Section 3.9 and Attachment III; FAMIS Contract, Section 3.9 and Attachment III, Section A.6, CCC Plus Contract, Section 9.16*)

2.9 Record Retention. Provider agrees to comply with all record retention requirements and, where applicable, the special reporting requirements on sterilizations and hysterectomies stipulated in the applicable State Contract. (*Medallion 3.0 Contract, Attachment III; FAMIS Contract, Attachment III, Section A.7*)

2.10 Maintenance of Records. Provider agrees to comply with the requirements for maintenance and transfer of medical records stipulated in the applicable State Contract and all Applicable Laws. (*12VAC5-408-210(A) and (B); Medallion 3.0 Contract, Section 14.19; FAMIS Contract, Section 14.19; FAMIS Regulations, 12VAC30-141-650(B) and 12VAC30-141-870(B)*)

#### 2.11 Access to Facilities and Records.

2.11.1 Provider agrees to provide representatives of Company, as well as duly authorized agents or representatives of the Department, the U.S. Department of Health and Human Services, and the State Fraud Unit access to its premises and its books, fee schedules, documents, papers, records, contracts and/or medical records in

accordance with the applicable State Contract. Provider must allow the Department, or its duly authorized representatives to inspect, copy, and audit any of Provider's medical and/or financial records. Provider agrees otherwise to preserve the full confidentiality of medical records in accordance with the applicable State Contract. Provider must forward to Company medical records within ten (10) working days of Company's request. (*Medallion 3.0 Contract, Section 14.19.B.I and Attachment III; FAMIS Contract, Section 14.19.B.I and Attachment III, Section A.8 and A.14; FAMIS Regulations, 12VAC30-141-650(C) and 12VAC30-141-870(C); CCC Plus Contract, Section 8.5.4.1*)

2.11.2 Provider shall allow duly authorized agents or representatives of the State or Federal Government, during normal business hours, access to its premises to inspect, audit, monitor or otherwise evaluate the performance of Provider's contractual activities and shall forthwith produce all records requested as part of such review or audit. In the event right of access is requested, Provider shall, upon request, provide and make available staff to assist in the audit or inspection effort, and provide adequate space on the premises to reasonably accommodate the State or Federal personnel conducting the audit or inspection effort. All inspections or audits shall be conducted in a manner as will not unduly interfere with the performance of Provider's activities. All information so obtained will be accorded confidential treatment as provided under Applicable Law. (*Medallion 3.0 Contract, Section 14.1; FAMIS Contract, Section 14.1*)

2.12 Member Access to Records. Provider agrees to the requirements for maintenance and transfer of medical records stipulated in the applicable State Contract. Provider further agrees to make medical records available to Members and their authorized representatives within ten (10) working days of the record request. (*Medallion 3.0 Contract, Attachment III; FAMIS Contract, Attachment III, Section A.9; CCC Plus Contract, Section 8.5.4.1*)

2.13 Provider Disclosures. Provider agrees to disclose the required information, at the time of application, credentialing, and/or recredentialing, and/or upon request, in accordance with 42 CFR § 455 Subpart B and relevant provisions of the applicable State Contract, as related to ownership and control, business transactions, and criminal conviction for offenses against Medicare, Medicaid, CHIP and/or Federal health care programs. See 42 CFR § 455, Parts 101 through 106 for definitions, percentage calculations, and requirements for disclosure of ownership, business transactions, and information on persons convicted of crimes related to any Federal health care programs. (*Medallion 3.0 Contract, Section 3.4.A, Section 13.3.A.II.c(v), and Attachment III; FAMIS Contract, Section 3.4.A and Section 13.3.A.II.c(v); CCC Plus Contract, Section 8.4.7*)

2.14 Confidentiality of Family Planning Services. Provider agrees to ensure confidentiality of family planning services in accordance with the applicable State Contract, except to the extent required by law, including, but not limited to, the Virginia Freedom of Information Act. (*Medallion 3.0 Contract, Attachment III; FAMIS Contract, Attachment III, Section A.10*)

2.15 No Barriers to Care. Provider agrees to not create barriers to access to care by imposing requirements upon Members that are inconsistent with the provision of Medically Necessary and covered Medicaid/FAMIS services. (*Medallion 3.0 Contract, Attachment III; FAMIS Contract, Attachment III, Section A.11*)

2.16 Provider Referrals and Hold Harmless. Provider agrees to clearly specify referral approval requirements to its providers and in any sub-subcontracts. Additionally, Provider hereby agrees that, if there is an intermediary organization between Company and Provider, the hold harmless requirement set forth in Section 4.3.2 of the Agreement shall include nonpayment by the Plan, Company, and the intermediary organization. Provider further agrees that the hold harmless requirement applies in circumstances where Provider fails to obtain necessary referrals, preauthorization, or fails to perform other required administrative functions. (*Virginia Code § 38.2-5805(C)(10); Medallion 3.0 Contract, Section 12.9 and Attachment III; FAMIS Contract, Section 12.9 and Attachment III, Section A.12*)

2.17 Restriction on Billing Members. Provider agrees that the restrictions on billing Members as set forth in Section 4.3 of the Agreement shall continue to be in effect even if Company becomes insolvent. (*Medallion 3.0 Contract, Attachment III; FAMIS Contract, Attachment III, Section A.13; CCC Plus Contract, Section 11.7*)

2.18 Prompt Provision of Covered Services. Provider shall promptly provide or arrange for the provision of all services required under the Agreement. This provision shall continue to be in effect for subcontract periods for

which payment has been made even if Provider becomes insolvent until such time as Members are withdrawn from assignment to Provider. (*Medallion 3.0 Contract, Attachment III; FAMIS Contract, Attachment III, Section A.15*)

2.19 PCP Obligation to Continue Services after Disenrollment. Except in the case of death or illness, Provider, if serving as a PCP, agrees to notify Company at least thirty (30) days in advance of disenrollment and agrees to continue care for his or her panel Members for up to thirty (30) days after such notification, until another PCP is chosen or assigned. (*Medallion 3.0 Contract, Attachment III; FAMIS Contract, Attachment III, Section A.16*)

2.20 PCP Panel. Providers serving as a PCP pursuant to the Agreement agree to act as a PCP for the predetermined number of Members set forth on the PCP Panel Schedule attached hereto, not to exceed the panel size limits set forth in the applicable State Contract. (*Medallion 3.0 Contract, Attachment III; FAMIS Contract, Attachment III, Section A.17; CCC Plus Contract, Section 9.8.2*)

2.21 Timeframe for Payment. Company agrees to pay Provider within thirty (30) days of the receipt of a claim for Covered Services rendered to a covered Member unless there is a signed agreement with Provider that states another timeframe for payment that is acceptable to Provider. (*Medallion 3.0 Contract, Attachment III; FAMIS Contract, Attachment III, Section A.18*)

2.22 State Appropriations. Notwithstanding any other provision to the contrary, the obligations of Virginia shall be limited to annual appropriations by its governing body for the purposes of the subcontract. (*Medallion 3.0 Contract, Attachment III; FAMIS Contract, Attachment III, Section A.19*)

2.23 Confidentiality of Medical Records. For all referrals that require the sharing of a Member's medical information, Provider shall obtain necessary written and signed informed consent from Member prior to release of Member's medical information. All requests for medical information shall be consistent with the confidentiality requirements of 42 CFR § Part 431, Subpart F. (*Medallion 3.0 Contract, Section 4.12.B; FAMIS Contract, Section 4.12.B*)

2.24 Member Rights. Provider shall comply with any Applicable Laws that pertain to member rights. (*Medallion 3.0 Contract, Section 6.9; FAMIS Contract, Section 6.9; CCC Plus Contract, Section 11.3*)

2.25 Emergency Services (Hospitals Only). In accordance with Section 1867 of the Social Security Act, if Provider is a hospital that offers Emergency Services, Provider shall perform a medical screening examination on all people who come to Provider seeking emergency care, regardless of their insurance status or other personal characteristics. If an Emergency Medical Condition is found to exist, Provider must provide whatever treatment is necessary to stabilize that condition. Provider may not transfer a patient in an unstabilized emergency condition to another facility unless the medical benefits of the transfer outweigh the risks, and the transfer conforms to all applicable requirements. (*Medallion 3.0 Contract, Section 7.2.G; FAMIS Contract, Section 7.2.G*)

2.26 Immunization Registry Database. To the extent possible, and as permitted by Virginia statute and regulations, Provider shall participate in the state-wide immunization registry database. (*Medallion 3.0 Contract, Section 7.2.J; FAMIS Contract, Section 7.2.J; CCC Plus Contract, Section 4.4.8*)

2.27 Members with Disabilities. Provider must ensure that Members with disabilities have effective communication with health care system participants in making decisions with respect to treatment options. (*Medallion 3.0 Contract, Section 7.6.A.V; FAMIS Contract, Section 7.6.A.V*)

2.28 Maternity Care. Provider shall screen pregnant women (or refer to an appropriate practitioner to screen) for prenatal depression in accordance with the American College of Obstetricians and Gynecologists (ACOG) standards. (*Medallion 3.0 Contract, Section 8.7.A; FAMIS Contract, Section 8.7.A*)

2.29 Company Right to Assess Claims of Fraud. Provider shall cooperate with Company in its process for assessing claims of fraudulent activity by Members and providers. Company may utilize, among other methods, computer software and periodic audits of medical records to perform such audits. (*Medallion 3.0 Contract, Section 9.2; FAMIS Contract, Section 9.2; CCC Plus Contract, Section 14.2*)

2.30 Provider Appeals. Provider must utilize and exhaust Company's internal appeals process as set forth in the Agreement before appealing to DMAS. (*Medallion 3.0 Contract, Section 10.2.B; FAMIS Contract, Section 10.2.A; CCC Plus Contract, Section 15.3 and 15.6*)

2.31 Provider Identifiers. In accordance with requirements set forth in 1932(d)(4) and 1173(b)(2) of the Social Security Act, Company shall assign a unique identifier to Provider, and Provider shall use this identifier when submitting data to Company. (*Medallion 3.0 Contract, Section 11.4; FAMIS Contract, Section 11.4; CCC Plus Contract, Section 8.5.2*)

2.32 Provider Bankruptcy. Provider shall notify Company of any bankruptcy filing on or before the date of such filing. (*Medallion 3.0 Contract, Section 14.29.B.VI; FAMIS Contract, Section 14.29.B.VI; CCC Plus Contract, Section 21.3.3*)

### **3.0 STATUTORY AND REGULATORY REQUIREMENTS FOR MANAGED CARE PLANS**

#### **3.1 Health Care Provider Panels**

3.1.1 For a period of at least 90 days from the date of the notice of Provider's termination from Company's provider panel, except when Provider is terminated for cause, Provider shall be permitted by Company to render health care services to any Members who were in an active course of treatment from Provider prior to the notice of termination and request to continue receiving health care services from Provider. (*Virginia Code § 38.2-3407.10(F)(1)*)

3.1.2 Notwithstanding the provisions of 3.1.1, Provider shall be permitted to continue rendering health services to any Member who has entered the second trimester of pregnancy at the time of Provider's termination of participation, except when Provider is terminated for cause. Such treatment shall, at the Member's option, continue through the provision of postpartum care directly related to the delivery. (*Virginia Code § 38.2-3407.10(F)(2)*)

3.1.3 Notwithstanding the provisions of 3.1.1, Provider shall be permitted to continue rendering health services to any Member who is determined to be terminally ill (as defined under § 1861 (dd)(3)(A) of the Social Security Act) at the time of Provider's termination of participation, except when Provider is terminated for cause. Such treatment shall, at the Member's option, continue for the remainder of the Member's life for care directly related to the treatment of the terminal illness. (*Virginia Code § 38.2-3407.10(F)(3)*)

3.2 Medically Necessary Services. Nothing contained in this Addendum or in the Agreement shall be construed to require Provider to deny Covered Services that Provider knows to be Medically Necessary and appropriate that are provided with respect to a specific Member or group of Members with similar medical conditions. (*Virginia Code § 38.2-4312(F)*)

3.3 Limitation on Remedies. None of Provider, its agents, trustees, or assignees may maintain any action at law against a Member to collect sums owed by Company or any intermediary organization between Company and Provider. (*Virginia Code § 38.2-5805(C)(2) and (5)*)

3.4 Urgent Care and Emergency Services. Provider shall allow its Members, on a 24-hour basis, (i) access to medical care or (ii) access by telephone to a physician or licensed health care professional with appropriate medical training who can refer or direct a Member for prompt medical care in cases where there is a need for urgent care or Emergency Services. Provider shall clearly notify Members of provisions for urgent care or Emergency Services when Provider is not available after hours. (*12VAC5-408-280(A) and (C)*)

### **4.0 REGULATORY REQUIREMENTS SPECIFIC TO MEDALLION 3.0 MANAGED CARE PLANS**

4.1 Compliance with Quality of Care Standards. Provider shall comply, and cause its employees, agents, independent contractors and subcontractors to comply, with all applicable federal and state mandates, community standards for quality of care, and standards developed pursuant to the DMAS managed care quality program. (*12VAC30-120-380(E)*)

4.2 Cost-Sharing. In accordance with 42 CFR § 447.50 through 42 CFR § 447.60, no provision contained in this Addendum or in the Agreement shall be construed to impose any cost sharing obligations on Members except as set forth in 12VAC30-20-150 and 12VAC30-20-160. (12VAC30-120-380(I))

## **5.0 COMMONWEALTH COORDINATED CARE PLUS (CCC PLUS) CONTRACT REQUIREMENTS FOR MANAGED LONG TERM SERVICES AND SUPPORTS (MLTSS)**

5.1 Coverage Responsibility for Behavioral Health Services. To the extent that Provider provides behavioral health services and Addiction and Recovery Treatment Services (ARTS), Provider must meet DMAS' qualifications as outlined in the most current DMAS behavioral health provider manuals, including the community mental health rehabilitative services (CMHRS), mental health clinic, and psychiatric services provider manuals published on the DMAS website and currently found at <http://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual>. Community Based Mental Health and ARTS providers (public and private) shall meet any applicable DBHDS certification standards. (CCC Plus Contract, Section 8.4.5)

5.2 Behavioral Health Services Outcomes. To the extent that Provider provides behavioral health services, Provider must collect clinical outcomes data as determined by Company and approved by the Department. Provider also must make available behavioral health clinical assessment, treatment planning, and outcomes data for quality, utilization, and network management purposes. (CCC Plus Contract, Section 10.14)

5.3 Addiction and Recovery Treatment Services. To the extent that Provider provides ARTS services, Provider shall comply with the following requirements:

5.3.1 Program Integrity Safeguards. Provider shall cooperate with Company in fulfilling Company's obligation to perform an annual review of Provider to assure that the health care professionals under contract with Provider are qualified to provide ARTS and that services are being provided in accordance with the Agreement, the American Society for Addiction Medicine (ASAM) criteria, and CCC Plus program requirements. (CCC Plus Contract, Section 4.2.3.1.10)

5.3.2 Community Integration. Provider shall provide ARTS services in a manner that demonstrates cultural and linguistic competency as detailed in the applicable State Contract. (CCC Plus Contract, Section 4.2.3.1.11)

5.3.3 Services for Adolescents and Youth with Substance Use Disorders (SUD). Provider shall not work with children under age 12 unless Provider has experience in addiction treatment with children and adolescents. (CCC Plus Contract, Section 4.2.3.1.12)

5.4 EDCD and Tech Waiver Participants. To the extent that Provider provides services to Elderly or Disabled with Consumer Direction Waiver (EDCD) and Tech Waiver participants, Provider shall comply with the provider requirements as established in the DMAS provider manuals published on the DMAS website and currently found at <http://www.virginiamedicaid.dmas.virginia.gov/wps/portal> and the following regulations: (i) ED CD Waiver – 12VAC30-120-900 through 12VAC30-120-995, and (ii) Tech Waiver – 12VAC30-120-1700 through 12VAC30-120-1770. All providers of CCC Plus Waiver services (including ADHC) shall maintain compliance with the provisions of the CMS Home and Community Based Settings Rule as detailed in 42 CFR § 441.301(c)(4)-(5) prior to executing a provider agreement. (CCC Plus Contract, Sections 4.7 and 8.4.6)

5.5 Inpatient Admission Privileges. To the extent that Provider provides inpatient services to Members, Provider shall have admitting and treatment privileges in a minimum of one general acute care hospital. (CCC Plus Contract, Section 8.2.2)

5.6 Critical Incidents. Provider shall report, respond to, and document critical incidents to Company in accordance with applicable requirements. "Critical incidents" shall include, but not be limited to, the following incidents: medication errors, severe injury or fall, theft; suspected physical or mental abuse or neglect; financial exploitation and death of a Member. The maximum timeframe for reporting an incident to Company shall be twenty-four (24) hours. The initial report of an incident within twenty-four (24) hours may be submitted verbally, in

which case Provider shall submit a follow-up written report within forty-eight (48) hours. (*CCC Plus Contract, Section 17.4*)

5.7 Provider-Preventable Conditions. Provider shall identify provider-preventable conditions as a condition of payment. Company shall not pay for provider-preventable conditions as set forth in 42 C.F.R. § 434.6(a)(12) and 42 C.F.R. § 447.26. (*CCC Plus Contract, Sections 12.4.13 and 17.5*)

5.8 Prohibited Actions. Provider shall not knowingly have an employment, consulting, provider agreement, or other agreement or relationship for the provision of items and services that are significant and material to the Provider's obligations under the applicable State Contract with any person, or affiliate of such person, who is excluded, under Federal law or regulation, from certain procurement and non-procurement activities. Further, no such person may have beneficial ownership of more than five (5) percent of Provider's equity or be permitted to serve as a director, officer, or partner of Provider. Provider is further prohibited from contracting with providers who have been terminated from the Medicaid program by DMAS for fraud, waste and abuse. Provider can screen managing employees, contractors, and other individuals against the HHS-OIG online exclusions database on a monthly basis to determine whether any such individuals have been excluded from participating in Federal health care programs. The HHS-OIG online exclusions database is available at <http://exclusions.oig.hhs.gov>. Provider shall immediately report to Company any exclusion information discovered. (*CCC Plus Contract, Sections 2.11 and 8.4.7*)

5.9 Protecting Member from Liability for Payment. Provider shall not deny any service covered under the applicable State Contract to a Member for failure or inability to pay any applicable charge or where Member, who, prior to becoming CCC Plus program eligible, incurred a bill that has not been paid. (*CCC Plus Contract, Section 11.7*)

5.10 Immunizations/Vaccinations. To the extent that Provider provides EPSDT services, Provider shall comply with the following requirements:

5.10.1 Provider shall render immunizations, in accordance with the EPSDT periodicity schedule specified in the most current Advisory Committee on Immunization Practices (ACIP) Recommendation, concurrently with the EPSDT screening. Provider shall not inappropriately refer a Member to other providers for immunizations. (*CCC Plus Contract, Section 4.4.8*)

5.10.2 If Provider is a PCP who administers childhood immunizations, Provider shall enroll in the Virginia Vaccines for Children program (VVFC), administered by the Virginia Department of Health. (*CCC Plus Contract, Section 4.4.8*)

5.10.3 If Provider is a PCP, Provider shall not be permitted to routinely refer Members to the local health department to receive vaccines.

5.11 Clean Claim. Company shall pay Provider in accordance with the terms of the applicable State Contract upon receipt of a clean claim. A clean claim is a claim that has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payments from being made on the claim under this title. See Sections 1816(c)(2)(B) and 1842(c)(2)(B) of the Social Security Act. (*CCC Plus Contract, Section 23.1*).

5.12 Medically Necessary or Medical Necessity. Per Virginia Medicaid, Medically Necessary or Medical Necessity is defined as an item or service provided for the diagnosis or treatment of an enrollee's condition consistent with standards of medical practice and in accordance with Virginia Medicaid policy (12 VAC 30-130-600) and EPSDT criteria (for those under age 21) and Federal regulations as defined in 42 CFR § 438.210 and 42 CFR § 440.230. (*CCC Plus Contract, Section 23.1*)

5.13 340B Providers. To the extent that Provider is a 340B entity, Provider must submit the actual acquisition cost as the ingredient cost on any 340B encounter/claim and must provide this information in the encounter files ultimately submitted to DMAS. (*CCC Plus Contract, Section 4.8.8*)

5.14 Standard Contract Elements. As required by Section 8.5.4.1 of the CCC Plus Contract, Provider agrees to comply with the following requirements:

5.14.1 Provider agrees to abide by all applicable provisions of the CCC Plus Contract.

5.14.2 Provider shall have a National Provider Identifier (NPI) number.

5.14.3 Provider shall meet Company's standards for licensure, certification, and credentialing.

5.14.4 Provider shall comply with all applicable Federal and State laws and regulations, including Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; the Americans with Disabilities Act of 1990 as amended; Health Insurance Portability and Accountability Act of 1996 (HIPAA) security and privacy standards, section 1557 of the Patient Protection and Affordable Care Act (including, but not limited to, reporting overpayments pursuant to state or federal law) and the Deficit Reduction Act of 2005 (DRA) requiring that emergency services be paid in accordance with the DRA provisions [Pub. L. No. 109-171, Section 6085], and as explained in CMS State Medicaid Director Letter SMDL #06-010. Provider shall maintain capacity to deliver services in a manner that accommodates the needs of its Members by: (*CCC Plus Contract, Section 9.17*)

5.14.4.1 Providing flexibility in scheduling to accommodate the needs of Members;

5.14.4.2 Providing interpreters or translators for Members who are deaf and hard of hearing and those who do not speak English;

5.14.4.3 Ensuring that individuals with disabilities are provided with reasonable accommodations to ensure effective communication, including auxiliary aids and services. Reasonable accommodations will depend on the particular needs of the individual;

5.14.4.4 Ensuring safe and appropriate physical access to buildings, services, and equipment;

5.14.4.5 Allowing extra time for Members to dress and undress, transfer to examination tables, and to understand the information provided by Provider so that Members can fully participate in the provision of care; and

5.14.4.6 Demonstrating compliance with the ADA by conducting an independent survey or site review of facilities for both physical and programmatic accessibility, documenting any deficiencies in compliance and monitoring correction of deficiencies.

5.14.5 Vehicles shall comply with the Americans with Disabilities Act specifications for transportation, 49 CFR § 38, subparts A and B. (*CCC Plus Contract, Section 8.4.2*)

5.14.6 Provider shall maintain records for ten (10) years from the close of the Provider Contract. For children under age 21 enrolled in the CCC Plus Waiver, Provider shall retain records for the greater period of a minimum of ten (10) years or at least six (6) years after the minor has reached 21 years of age per 12VAC30-120-1730.

5.14.7 Provider shall provide copies of Member records and access to its premises to representatives of Company, as well as duly authorized agents or representatives of the Department, the U.S. Department of Health and Human Services, and the State Medicaid Fraud Unit.

5.14.8 Provider shall provide a copy of a Member's medical records to the Member and his or her authorized representatives as required by Company and within no more than ten (10) days of the Member's request.

5.14.9 Provider shall disclose the required information, at the time of application, credentialing, and/or recredentialing, and/or upon request, in accordance with 42 C.F.R. § 455 Subpart B, as related to ownership and control, business transactions, and criminal conviction for offenses against Medicare, Medicaid, CHIP and/or other Federal health care programs. See 42 C.F.R. § 455, Parts 101 through 106 for definitions, percentage calculations,

and requirements for disclosure of ownership, business transactions, and information on persons convicted of crimes related to any Federal health care programs. (*CCC Plus Contract, Section 8.4.7*)

5.14.10 Provider shall screen its employees and contractors initially and on an ongoing monthly basis to determine whether any of its employees/contractors have been excluded from participation in Medicare, Medicaid, SCHIP, or any Federal health care programs (as defined in Section 1128B(f) of the Social Security Act) and not employ or contract with an individual or entity that has been excluded or debarred. Provider shall immediately report to Company any exclusion information discovered. Provider is hereby informed that civil monetary penalties may be imposed against providers who employ or enter into contracts with excluded individuals or entities to provide items or services to CCC Plus Members.

5.14.11 Provider shall submit utilization data for Members in the format specified by Company, consistent with Company obligations to the Department as related to quality improvement and other assurance programs as required in the Medicaid CCC Plus Contract.

5.14.12 Provider shall comply with corrective action plans initiated by Company.

5.14.13 Provider shall clearly specify referral approval requirements to its providers and in any sub-contracts.

5.14.14 Provider shall hold Members harmless for charges for any Medicaid covered service. Provider shall accept Company payment as payment in full except for patient pay amounts and shall not bill or balance bill a Medicaid Member for Medicaid covered services provided during the Member's period of enrollment. The collection or receipt of any money, gift, donation or other consideration from or on behalf of a CCC Plus recipient for any Medicaid covered service provided is expressly prohibited. This includes those circumstances where Provider fails to obtain necessary referrals, service authorization, or fails to perform other required administrative functions. (*CCC Plus Contract, Section 11.7*)

5.14.15 Should an audit by Company or an authorized state or federal official result in disallowance of amounts previously paid to Provider, Provider will reimburse Company upon demand. Provider shall not bill the Member in these instances.

5.14.16 Any conflict in the interpretation of Company's policies and MCO Network Provider contract shall be resolved in accordance with Federal and Virginia laws and regulations, including the State Plan for Medical Assistance Services and Department memos, notices and provider manuals. Provider shall comply with Federal contracting requirements described in 42 CFR Part 438.3, including identification of/non-payment of provider-preventable conditions, conflict of interest safeguards, inspection and audit of records requirements, physician incentive plans, recordkeeping requirements, etc.

5.14.17 Provider shall comply with the claim processing and payment provisions as described in the Provider Payment Section of the CCC Plus Contract.

5.15 Special Provisions for Certain Provider Agreements. As required by Section 8.5.4.2 of the CCC Plus Contract, Provider agrees to comply with the following requirements, as applicable:

5.15.1 To the extent that Provider provides LTSS, ARTS, or Early Intervention services, Provider shall use DMAS' established billing codes as described in the CCC Plus Coverage Chart.

5.15.2 To the extent that Provider provides LTSS services, Provider shall comply with the CMS Federal Home and Community Based Services (HCBS) Settings Rule detailed in 42 C.F.R. § 441.301(c)(4)-(5).

5.15.3 To the extent that Provider is a Nursing Facility or provides LTSS, ARTS, or Early Intervention services, Provider shall comply with the special claim processing and payment provisions as described in the Provider Payment Section of the CCC Plus Contract.

5.16 Special Provisions for Transportation Services. To the extent that Provider provides transportation services, Provider agrees to comply with the following requirements:

5.16.1 Driver Training. Provider acknowledges and agrees that all drivers who perform transports at a hand-to-hand or door-to-door level of assistance complete PASS training prior to performing any trips for those levels of assistance. *(CCC Plus Contract, Section 4.10.8)*

5.16.2 Attendants. Company must approve all uses of an attendant by Provider. The transportation attendant must be an employee of a Non-Emergency Medical Transportation (NEMT) provider, approved and reimbursed by Company, and is responsible for assisting the driver and accompanying a Member or group of Members during transport while ensuring safe operation of the vehicle and Members. *(CCC Plus Contract, Section 4.10.9)*

5.17 Special Provisions for Non-Emergency Medical Transportation Services. To the extent that Provider provides NEMT services, Provider agrees to comply with the following requirements:

5.17.1 Driver, Attendant, and Vehicle Requirements. Company has the right and obligation to verify that all vehicles and drivers meet the requirements for training, licensing, vehicle inspection, registration, and insurance coverage as defined by the Department's fee-for-service NEMT program. Provider shall cooperate with Company in fulfilling this obligation. *(CCC Plus Contract, Section 4.10.11)*

5.17.2 Passenger Safety Requirements. Provider agrees to comply with the passenger safety requirements set forth in the CCC Plus Contract. *(CCC Plus Contract, Section 4.10.12)*

5.17.3 Driver Trip Logs. Provider shall maintain trip logs in accordance with the CCC Plus Contract. The Department may audit the trip logs for compliance and completeness. *(CCC Plus Contract, Section 4.10.13)*

5.18 Network Provider Contract Supplement (Provider Manual). A Provider Manual may be used to supplement the Agreement. The Provider Manual, including any amendments and revisions, is incorporated into Provider's obligations under the Agreement by this reference. It is understood that the Agreement takes precedence over any language in the Provider Manual. *(CCC Plus Contract, Section 8.5.5)*

5.19 Notification Obligations to Company and DMAS. Provider shall notify Company within sixty (60) days of any changes to a provider or subcontractor agreement regarding termination, pending termination, or pending modification in the subcontractor's or provider's terms that could reduce Member access to care. This written notice must occur in advance of the formal notification of termination from Company's or Provider's network. *(CCC Plus Contract, Section 8.5.6)*

5.20 Prohibited Contract Elements. In accordance with Section 8.5.3 of the CCC Plus Contract, nothing in the Agreement or in this Addendum shall be construed to:

5.20.1 Terminate legal liability of Company, Provider or its providers and subcontractors in the CCC Plus Contract; or

5.20.2 Require as condition of participation or contracting in the CCC Plus program that Provider:

5.20.2.1 Shall not contract with other CCC Plus program contractors or DMAS' other managed care program contractors;

5.20.2.2 To the extent enrolled in Company's CCC Plus program network, also participate in Company's other lines of business (e.g., commercial managed care network). However, this provision does not preclude Company from requiring its other managed care (commercial, Medicare, etc.) network providers to participate in their CCC Plus program provider network; and

5.20.2.3 Abide by terms that limit Provider's participation with other CCC Plus program contractors.

5.21 Protection of Member-Provider Communications. Nothing in this Addendum or the Agreement shall prohibit or otherwise restrict Provider from advising a Member about his or her health status or medical care or treatment options for Member's condition or disease; information Member needs in order to decide among all relevant treatment options; risk, benefits and consequences of treatment or non-treatment; and/or Member's right to participate in decisions about his or her health care, including the right to refuse treatment and to express preferences about future treatment decisions, regardless of whether benefits for such care or treatment are provided under the applicable State Contract, if Provider is acting within the lawful scope of practice. (*CCC Plus Contract, Section 11.10*)

5.22 HIPAA Disclaimer. To the extent that Provider renders services under the CCC Plus Contract on behalf of Company, and Provider receives or has access to PHI, Provider agrees to sign an agreement with Company that complies with HIPAA and to be bound by the same restrictions, terms, and conditions relating to PHI that apply to Company under the CCC Plus Contract. (*CCC Plus Contract, Section 16.11.4*)

5.23 Exceptional Processing and Payment Rules.

5.23.1 Company and Provider shall comply with all exceptional processing and payment rules for Nursing Facilities, LTSS (including when LTSS services are covered under EPSDT), ARTS and Early Intervention in accordance with the CCC Plus Contract. Company may reimburse based on an alternative payment methodology or value-based payment if mutually agreed upon by Provider and Company. (*CCC Plus Contract, Section 12.4.2*)

5.23.2 Following the Department's policy, Company shall receive an attestation by an authorized representative of a Nursing Facility on the DMAS-80 (Patient Intensity Rating System Review (PIRS) available at [www.virginiamedicaid.dmas.virginia.gov](http://www.virginiamedicaid.dmas.virginia.gov) under the search for forms) that the UAI has been completed prior to payment to a NF for that admission. (*CCC Plus Contract, Section 12.4.2*)

5.24 Payment Suspension. Provider acknowledges and agrees that Company is required to suspend payments to Provider in the event that the Department has determined there to be a credible allegation of fraud against Provider. (*CCC Plus Contract, Section 14.15.6*)

PCP Panel Schedule

*(Medallion 3.0 Contract, Section 3.5 and Attachment III;  
FAMIS Contract, Section 3.5 and Attachment III, Section A.17;  
CCC Plus Contract, Section 9.8.2)*

A Provider acting as a PCP shall accept new Members as patients until such Provider's panel consists of a minimum number of Members for each Plan in which Provider participates, as indicated below.

Medallion III: \_\_\_\_\_ Members

FAMIS: \_\_\_\_\_ Members

CCC Plus: \_\_\_\_\_ Members

Provider shall continue to accept new Members as otherwise required by the Agreement, but may not exceed the panel size limits set forth in the applicable State Contract.

## ADDENDUM B

### MEDICARE ADDENDUM (Aetna Better Health of Virginia)

This Medicare Addendum governs the provision of Covered Services to Members dually eligible for both Medicare and Medicaid and covered by a Medicare Plan offered by Company, such as a Dual-Eligible Special Needs Plan (D-SNP), as well as the provision of any administrative or health-benefit management services/functions that relate to such Medicare Plan, to the extent applicable to Provider's services and obligations under the Agreement. This Addendum is incorporated into the Agreement between Company (or its affiliate) and the provider, vendor, contractor, or other entity executing the Agreement, as identified on the first page of the Agreement ("Provider"). This Addendum and the Agreement may be revised as directed by the State of Virginia ("State") and/or by CMS.

For purposes of this Addendum, the individuals who are enrolled with Company under a Medicare Plan may be referred to as "Members" or "Enrollees." All capitalized terms not defined in this Addendum shall have the meanings ascribed to them in the Agreement. All provisions of this Addendum that by their nature should survive termination of the Agreement and/or termination of Provider's provision of Covered Services to Members, or, Provider's provision of administrative or health-benefit management services/functions that relate to those Covered Services, shall survive such termination.

#### A. Medicare Requirements

Without limiting any obligation of Provider under the Agreement, Provider shall comply with, and shall cause its Downstream Entities to comply with, this Addendum (including Schedule 1) when providing Covered Services to Members dually eligible for both Medicare and Medicaid, and when providing administrative or health-benefit management services/functions (or other functions delegated to Provider), as applicable, that relate to those Covered Services ("**Medicare Services**"). The term "Downstream Entities" shall have the meaning ascribed to it in Schedule 1. With respect to the requirements set forth in this Section: (a) the term "Provider" shall include Provider's permanent and temporary employees; (b) the Members who are dually eligible for both Medicare and Medicaid shall collectively be referred to as the "**Medicare Members**"; and (c) the managed-care plan that Company offers shall be referred to as the "**Medicare Plan**." Provider acknowledges and agrees that all terms of Schedule 1 apply equally to services provided in connection with the Medicare Plan, even if Schedule 1 only refers to Medicare Advantage products. The requirements set forth in this Section (including Schedule 1) shall be governed by federal laws, regulations, and agency requirements applicable to the Medicare program. In the event that changes to such governing laws, regulations, or agency requirements occur, the new law, regulation, or agency requirement that is applicable to the Medicare program shall supersede to the extent required by such changes.

#### 1. PROVIDER OBLIGATIONS.

A. Addendum Applicability; Requirements. Provider agrees that all provisions of this Addendum (including Schedule 1, attached hereto and incorporated herein, and any delegated function-specific Schedules appended hereto), shall apply equally to any employees (temporary or permanent), partners, individual practitioners, independent contractors, subcontractors, downstream entities, or related entities of Provider that provide Covered Services to Members, or that provide administrative or health-benefit management services/functions that relate to those Covered Services. Provider agrees that, with respect to all such aforementioned individuals and/or entities: (a) Provider's contracts shall be in writing and shall specify, as applicable, the delegated activities and reporting responsibilities of those individuals and/or entities; (b) Provider shall cause those individuals and/or entities to comply with this Addendum, including Schedule 1, and with all applicable State and federal laws and regulations (including applicable CMS instructions and directives), to the extent applicable to the services that those individuals and/or entities provide; and (c) Provider either has the authority to bind those individuals and/or entities (and shall provide written evidence of same to Company upon request), or shall include in Provider's contracts with such individuals and/or entities all of the contractual and legal obligations and duties imposed upon Provider in the Agreement and this Addendum (and Provider shall provide written evidence of same Company upon request). This includes any such aforementioned individuals and/or entities that may perform services under the Agreement in Provider's offices, on behalf of Provider, for which Provider bills

such services under the Agreement. To the extent that the State and/or CMS requires additional provisions to be included in Provider's contracts with such aforementioned individuals and/or entities, Provider shall amend its contracts in conformance therewith. [42 C.F.R. § 422.504]

B. Compliance: Cooperation. Provider agrees that all Medicare Services and other activities performed by Provider under the Agreement, including without limitation any activities and responsibilities that Company delegates to Provider, will be performed consistent with and will comply with Company's contractual and legal obligations and duties under Company's Medicare agreement with CMS and under applicable Medicare laws, regulations, rules, and other directions of CMS. Upon request, Provider shall immediately provide to Company any information that is required by Company to meet its reporting obligations to CMS, including without limitation, physician incentive plan information, if applicable. Provider agrees to cooperate with and participate in internal and external review procedures necessary to allow Company to process Medicare appeals and grievances in accordance with Medicare laws, regulations, and CMS instructions. [42 C.F.R. § 422.504(i)(3)(iii)]

C. Compliance Program and Anti-Fraud Initiatives. Provider shall (and shall cause its Downstream Entities, if any, to) institute, operate, and maintain an effective compliance program to detect, correct, and prevent the incidence of non-compliance with CMS requirements and the incidence of fraud, waste, and abuse ("FWA") relating to the operation of the Medicare Plan. Such compliance program shall be appropriate to the organization and operations of Provider and Provider's Downstream Entities and shall include:

(1) Written compliance policies and standards of conduct that are comparable to Aetna's compliance policies/Aetna Code of Conduct and articulate the entity's commitment to comply with federal and state laws, ethical behavior, and compliance program operations. Provider will disseminate either Aetna's compliance policies/Aetna Code of Conduct or comparable versions to Provider's employees, officers, and Downstream Entities within ninety (90) days of hire/contracting, when updates are made, and annually thereafter.

(2) Reporting mechanisms communicated to Provider's employees and Downstream Entities for their use in adhering to the expectation that Provider, its employees, and its Downstream Entities report potential non-compliance or FWA issues (internally and to Company, as applicable) and understand their obligation to report. Provider must publicize the reporting methods to Provider employees and Downstream Entities along with a no-tolerance policy for retaliation or retribution for good-faith reporting.

(3) Completion of CMS's Medicare Learning Network<sup>®</sup> "Medicare Parts C and D Fraud, Waste, and Abuse Training and Medicare Parts C and D General Compliance Training" by Provider employees, officers, and Downstream Entities initially within ninety (90) days of hire/contracting and at least annually thereafter, unless exempt from such training under relevant CMS regulations. Training may be completed in one of two ways: (1) by completing the general compliance and FWA training modules located on the CMS Medicare Learning Network; or (2) by downloading, viewing or printing the content of the then current CMS standardized training modules from the CMS website to incorporate into Provider's and/or Downstream Entity's organization's existing compliance training materials/systems. The CMS training content may not be changed but Provider and/or its Downstream Entities may add to it to cover topics specific to its organization.

(4) Processes to oversee and ensure that Provider and Provider's Downstream Entities maintain compliance with processes to oversee and ensure that: (1) Provider and Provider's Downstream Entities maintain compliance with CMS compliance program requirements, and (2) Provider's Downstream Entities perform Medicare Services consistent with this Agreement and the agreement between Provider and such Downstream Entities. Provider's oversight under this Agreement shall include: (1) imposition of disciplinary actions, as needed, to ensure employee compliance with CMS compliance program requirements, and (2) implementation of corrective actions (up to and including contract termination), as needed, with

respect to its Downstream Entities to ensure Downstream Entity compliance with applicable CMS requirements, including the CMS compliance program requirements, this Agreement, and Provider's contract with the Downstream Entity.

(5) Retention of evidence showing that Provider and Provider's Downstream Entities complied with the requirements set forth in this Section. Such evidence must be maintained for at least the period of time specified in Section A.1.G. hereof and shall be made available to Company and CMS, upon request. Provider shall complete attestations in the form and manner requested by Company to confirm its compliance with this Section on an annual basis.

[Chapter 21 of the Medicare Managed Care Manual]

D. Federal Fund Obligations. Provider understands and agrees that payments received by Company for the Medicare Plans from CMS pursuant to the Medicare Plan's contract with CMS, as well as payments that Provider receives from Company for performing services and functions under the Agreement, constitute the receipt of federal funds. As a result, Provider, by entering into the Agreement and the terms of this Addendum, is subject to laws applicable to individuals/entities receiving federal funds, including but not limited to Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 C.F.R. part 84, the Age Discrimination Act of 1975 as implemented by regulations at 45 C.F.R. part 91, the Rehabilitation Act of 1973, and the Americans with Disabilities Act. [Section 120 of Chapter 11 of the Medicare Managed Care Manual]

E. Continuation of Services. In the event Company's contract for the Medicare Plans with CMS terminates or Company becomes insolvent, Provider shall continue to provide Covered Services to Medicare Members who are hospitalized through the date of discharge. Provider is prohibited by law from billing Medicare Members for such Covered Services. This provision shall survive the termination of the Agreement, regardless of the reason for termination, including the insolvency of Company, and shall supersede any oral or written agreement between Provider and a Medicare Member. [42 C.F.R. § 422.504(g)(2)(i) and (ii)]

F. Policies, Programs & Procedures. Provider agrees to comply with Company's policies and procedures (which Company shall provide to Provider upon request) which operationalize many of the requirements of the Agreement, this Addendum, and the Medicare Program. Provider agrees to comply with Company's quality improvement, administrative processes and procedures, utilization review, peer review, grievance procedures, credentialing and recredentialing procedures, and any other policies Company may implement, including amendments made to the above mentioned policies, procedures and programs from time to time. In the event that a Company policy or procedure conflicts with a provision in the Agreement, then the language in the Agreement (including all amendments, exhibits, and attachments thereto) shall govern. [Section 100.4 of Chapter 11 of the Medicare Managed Care Manual]

G. Maintenance of Records. Provider, on behalf of itself and its Downstream Entities (if any), shall preserve records applicable to Medicare Members and/or to Company's participation in the Medicare Program, for the longer of: (i) the period of time required by state and federal law, or (ii) ten (10) years. In addition, to the extent applicable to Provider, Provider, on behalf of itself and any Downstream Entities with whom Provider has contracted, agrees to comply with 42 C.F.R. § 422.2480(c) and to maintain all records, if any, containing data used by Company to calculate Medicare medical loss ratios ("MLRs") for Company's Medicare Plans and/or evidence needed by Company and/or federal governmental authorities with jurisdiction to validate MLRs (collectively, "MLR Records") for a minimum of ten (10) years from the date such MLRs were reported by Company to CMS. This provision shall survive the termination of the Agreement, regardless of the cause of termination. [42 C.F.R. § 422.504(i)(2)(i)(ii) and 42 C.F.R. § 422.2480(c)(1)]

H. Contracts with Excluded Entities. Provider understands and agrees that no person or entity that provides Medicare Services, directly or indirectly, for Company's Medicare Plans, may be an individual or entity excluded from participation in Medicare under Section 1128 or 1128A of the Social Security Act. Provider hereby certifies that no such excluded person or entity will be employed by or

utilized by Provider or by any of Provider's Downstream Entities to directly or indirectly perform Medicare Services under this Agreement. Provider agrees to review the Department of Health and Human Services ("HHS") Office of Inspector General List of Excluded Individuals and Entities and the General Services Administration System for Awards Management (collectively, "Exclusion Lists") to ensure that no persons or entities employed by or utilized by Provider or by any of Provider's Downstream Entities are included on such Exclusion Lists. Provider agrees to review the Exclusion Lists prior to initially hiring, appointing, or contracting with any new employee, temporary employee, or Downstream Entity, and at least once per month thereafter to confirm that such persons and entities are not included on such Exclusion Lists. Provider agrees that if any such person or entity utilized by Provider to directly or indirectly perform Medicare Services under the Agreement appears on an Exclusion List and/or is excluded from participation in any federally-funded health program, Provider will immediately remove the employee, temporary employee, or Downstream Entity from any work related directly or indirectly to Company's Medicare Plan, and take all corrective actions required under applicable laws, rules, or regulations. In the event Provider or any employee, temporary employee, or Downstream Entity of Provider that directly or indirectly performs Medicare Services under this Agreement is listed in an Exclusion List after the Effective Date of this Addendum, Company shall have the right, in its sole discretion and judgment, to terminate Provider's participation in Company's Medicare Plan in accordance with the Agreement or to disqualify any such person or entity on the Exclusion List from providing any part of the Medicare Services. [42 C.F.R. §§ 422.503(b)(4)(vi)(F), 422.752(a)(8), 423.504(b)(4)(vi)(F), 423.752(a)(6) & 1001.1901 and Section 50.6.8 of the Medicare Managed Care Manual]

I. Offshore Services. Provider is prohibited from performing, and is prohibited from engaging or paying any individual or entity to perform, any services for the Medicare Plan if Provider or such individual or entity is physically located outside of one of the fifty United States or one of the United States Territories (*i.e.*, American Samoa, Guam, Northern Marianas, Puerto Rico, and Virgin Islands) ("Offshore Services"), unless Company, in its sole discretion and judgment, agrees in advance and in writing to the provision of such Offshore Services by Provider and/or such individual or entity. Provider agrees that Company has the right to audit Provider and/or such individual or entity prior to the provision of Offshore Services for the Medicare Plan. Additionally, Provider represents and warrants that it does not, and will not, permit any Medicare Member's protected health information (PHI), or any other information that Company or Provider has obtained in connection with the Agreement, to be accessible by any individual or entity that is physically located outside of one of the fifty United States or one of the United States Territories without prior written notice to Company and without Company's prior written approval of same. In the event that Company agrees in advance and in writing to the provision of Offshore Services that involve Medicare Member protected health information (PHI), such Offshore Services are subject to CMS reporting within thirty (30) days of: (1) performing, or contracting to perform, such Offshore Services, and (2) any time Provider changes the Offshore Services being performed. [CMS Memo dated July 23, 2007 on "Sponsor Activities Performed Outside of the United States" and CMS Questions and Answers dated September 20, 2007 on "Sponsor Activities Performed Outside of the United States"]

J. Submission of Encounter Data. Provider hereby acknowledges that Company is required to provide CMS and other federal and state regulatory agencies and accrediting organizations with encounter data as requested by such agencies and organizations. Such data may include medical records and all other data necessary to characterize each encounter between Provider and a Medicare Member. Provider agrees to cooperate with Company and to provide Company with all such information in such form and manner as requested by Company. Provider agrees to immediately notify Company if any encounter data that Provider submitted to Company for Medicare Members is inaccurate, incomplete, or erroneous, and to cooperate with Company to correct erroneous encounter data to ensure Company's compliance with Medicare laws, rules, and regulations and CMS instructions. [42 C.F.R. § 422.310]

K. Certification of Data. Provider recognizes that Company is required to certify the accuracy, completeness, and truthfulness of data that CMS requests. Such data include encounter data, payment data, and any other information provided to Company by its contracted providers and Downstream Entities. To the extent that Provider generates and/or compiles and provides to Company (either on its own or through its Downstream Entities) any data that Company, in turn, submits to CMS, Provider certifies, to the best of its knowledge and belief, that such data is accurate, complete, and truthful. Upon request,

Provider shall make such certification in the form and manner prescribed by Company. [42 C.F.R. § 422.504(1)(3)]

L. Medicare Member Complaints. Provider agrees to cooperate with Company in resolving any Medicare Member complaints related to coverage or the provision of Covered Services. Company will notify Provider as necessary concerning all Medicare Member complaints involving Provider. Provider shall, in accordance with the Provider's regular procedures, investigate such complaints and respond to Company in the required time. Provider shall use best efforts to resolve complaints in a fair and equitable manner. [42 C.F.R. § 422.562(a)]

M. Enrollment as Medicare Provider. To the extent that Provider prescribes drugs covered under Medicare Part D to Medicare Members who have Medicare prescription drug ("MA-PD") coverage offered by Company, Provider agrees to comply with the requirements set forth in 42 C.F.R. § 423.120(c)(6), including without limitation the requirement that Provider be enrolled in Medicare in an approved status in order for its prescriptions to be covered under Medicare Part D. [42 C.F.R. § 423.120(c)(6)]

N. Home Infusion Drugs. The following provisions shall only apply to Provider if Provider dispenses to a Medicare Member home infusion drugs that are covered under Medicare Part D and the Medicare Member has MA-PD coverage offered by Company ("Home Infusion Drug"):

1. With respect to Home Infusion Drugs, Company will pay clean claims (as defined in 42 C.F.R. § 423.520(b)) submitted by Provider on behalf of Medicare Members within 14 days for electronic claims and within 30 days for claims submitted otherwise. [42 C.F.R. § 423.505(i)(3)(vi)]

2. Home Infusion Drugs will be reimbursed (as applicable) in accordance with a fee schedule, or the third-party pricing source (*e.g.*, Medi-Span) otherwise agreed upon as set forth in the Agreement or Provider's agreement with Company's Pharmacy Benefit Manager ("PBM"). [42 C.F.R. § 423.505(i)(3)(viii)(B)]

3. If a prescription drug pricing standard is used for reimbursement of Home Infusion Drugs, updates to such a standard will occur not less frequently than once every 7 days beginning with an initial update on January 1 of each year, to accurately reflect the market price of acquiring the Home Infusion Drug. [42 C.F.R. § 423.505(i)(3)(viii)(A)]

4. In accordance 42 C.F.R. § 423.120(c)(3), Provider agrees to submit claims for Home Infusion Drugs to Company or its PBM whenever the Medicare Member's ID card is presented or is on file at the Provider, unless the Medicare Member expressly requests that the claim not be submitted to Company or its PBM. [42 C.F.R. § 423.120(c)(3)]

5. Provider must submit claims for Home Infusion Drugs in real time by means of point of service claims adjudication systems in compliance with CMS standards. [42 C.F.R. § 423.505(b)(17)]

6. Provider must provide Medicare Members with access to the negotiated prices (as defined in 42 C.F.R. § 423.100) for Home Infusion Drugs to Members. [42 C.F.R. § 423.104(g)(1)]

7. Provider must charge/apply the correct cost-sharing amount to the Medicare Member for Home Infusion Drugs. [42 C.F.R. § 423.104]

8. At the time of purchase by a Medicare Member, Provider must inform the Medicare Member of any differential between the price of the Home Infusion Drug being dispensed and the price of the lowest priced generic version of that Home Infusion Drug available from Provider, unless the Home Infusion Drug being dispensed is the lowest priced generic

version of that Home Infusion Drug. [42 C.F.R. § 423.132]

9. Provider agrees to ensure that the professional services and ancillary supplies necessary for Home Infusion Drugs are in place before dispensing Home Infusion Drugs to a Medicare Member in his/her place of residence. [42 C.F.R. § 423.120(a)(4)(iii)]

10. Provider agrees to provide delivery of Home Infusion Drugs within 24 hours of a Medicare Member's discharge from an acute setting, or later if so prescribed. [42 C.F.R. § 423.120(a)(4)(iv)]

11. Provider shall submit to Company (not PBM) claims for equipment, supplies, and professional services associated with Home Infusion Drugs dispensed by Provider to a Medicare Member that are covered under Medicare Part C.

O. Marketing. Consistent with federal laws, regulations, and agency requirements applicable to the Medicare program, Provider shall not: (1) engage in any marketing or sales activities that could mislead or confuse Medicare Members, or (2) market or advertise non-health care related products to Medicare Members or prospective Medicare Members. Further, Provider shall at all times comply with the then-current Medicare Marketing Guidelines. [2017 Medicare Marketing Guidelines, as amended from time to time]

P. Non-Covered Services. Provider shall not hold a Medicare Member financially responsible for payment of a service not covered under the Member's Plan ("Non-Covered Service") unless the Medicare Member has received a pre-service organization determination notice of denial from Company before such services are rendered. Provider acknowledges and agrees that if Provider renders Non-Covered Services to a Medicare Member who has not received a pre-service organization determination notice of denial from Company, the Provider must hold the Medicare Member harmless for the Non-Covered Services and cannot charge the Medicare Member any amount beyond the normal cost-sharing amounts (*i.e.*, copayments, coinsurance, and/or deductibles). With respect to those Non-Covered Services that are clearly listed as exclusions under the Member's Medicare Plan, a pre-service organization determination is not required in order for Provider to hold the Medicare Member financially liable for such Non-Covered Services. [CMS Memo dated May 5, 2014 "Improper Use of Advance Notices of Non-coverage"]

Q. Dual-Eligible Hold Harmless. Provider acknowledges and agrees that Medicare Members are not responsible for paying to Provider any copayments, coinsurance, or deductibles for Medicare Part A and Part B services ("Cost Sharing Amounts") when the State Medicaid plan is responsible for paying such Cost Sharing Amounts. Provider furthermore agrees that it will not collect Cost Sharing Amounts from Medicare Members when the State is responsible for paying such Cost Sharing Amounts, and will, instead, either accept Company's payment for Covered Services as payment in full for Covered Services and applicable Cost Sharing Amounts, or bill the applicable State Medicaid plan for the appropriate Cost Sharing Amounts owed by the State Medicaid plan. [42 C.F.R. § 422.504(i)(3)(i)]

## **2. OTHER TERMS.**

A. Company shall not pay any amounts beyond the amounts set forth in the applicable Services and Compensation Schedule (or other analogous compensation schedule appended to the Agreement), including but not limited to any incentive payments that may be payable under traditional Medicare, except as expressly required by the Agreement or applicable law. Furthermore, Provider and Company each acknowledge and agree that payments under the Medicare program to providers, suppliers, and Company may be adjusted as the result of legislation, regulation, executive order, or other federal mandate ("Medicare Payment Adjustment"). Furthermore, any such Medicare Payment Adjustment could result in an increase or decrease in Medicare payments. In accordance with the terms of the Agreement, Provider and Company agree that, in the event of a Medicare Payment Adjustment, Company's payment to Provider will be adjusted in accordance with the Medicare Payment Adjustment. Company shall adjust payments under the Agreement for Covered Services rendered by Provider on and after the effective date of

the Medicare Payment Adjustment, and shall continue to adjust payments to Provider for Covered Services until the earlier of (i) the discontinuation of the Medicare Payment Adjustment, or (ii) the replacement of the Medicare Payment Adjustment by a subsequent Medicare Payment Adjustment.

B. Pursuant to Section A.1.K. of this Addendum, Provider certifies that the diagnosis codes submitted to Company for Medicare Members that Company is required to submit to CMS will be accurate, complete, and truthful (the "Certification"). Provider acknowledges and agrees that Company may impose a penalty on Provider not to exceed five thousand dollars (\$5,000) for each instance that Provider submits a diagnosis code to Company for a Medicare Member that does not comply with this Certification because the diagnosis code was not submitted in the format described in 42 C.F.R. § 422.310 or any subsequent or additional federal regulations. For purposes of this Section, "diagnosis code" shall mean an International Classification of Diseases-10th Edition-Clinical Modification (ICD-10-CM) code or its successor.

## SCHEDULE 1 TO ADDENDUM B

### MEDICARE REQUIRED PROVISIONS

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 Company (or its affiliate, as the case may be) and Provider (referred to in this Schedule 1 as “FDR”) not inconsistent herein shall remain in full force and effect. This Addendum shall supersede and replace any inconsistent provisions to such Agreement; to ensure compliance with required CMS provisions, and shall continue concurrently with the term of such Agreement.

NOW, THEREFORE, the parties agree as follows:

#### **A. Definitions:**

1. Centers for Medicare and Medicaid Services (“CMS”): the agency within the Department of Health and Human Services that administers the Medicare program.
2. 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.
3. 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.
4. Final Contract Period: the final term of the contract between CMS and the Medicare Advantage Organization.
5. 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.
6. 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.
7. 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.
8. Member or Enrollee: a Medicare Advantage eligible individual who has enrolled in or elected coverage through a Medicare Advantage Organization.
9. 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.
10. 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.

## **B. Required Provisions:**

FDR 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's contract with Company (or its affiliate, as the case may be) (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)] and [42 CFR §423.505]
2. HHS, the Comptroller General, or their designees have the right to audit, evaluate, collect, and inspect any records under paragraph 1 of this amendment directly from any First Tier Entity, Downstream Entity, or Related Entity. For records subject to review under paragraph 1, except in exceptional circumstances, CMS will provide notification to the MA organization that a direct request for information has been initiated. [42 C.F.R. §§ 422.504(i)(2)(ii) and (iii)]
3. FDR 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] and [42 CFR §423.136]
4. 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)] and [42 CFR §423.505(i)(3)(i)]
5. 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. FDR 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)]
6. Any services or other activity performed in accordance with a contract or written agreement by FDR are consistent and comply with the MA organization's contractual obligations. [42 C.F.R. § 422.504(i)(3)(iii)] and [42 CFR §423.505(i)(3)(iii)]
7. 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 MA Organization/Physician and the provider. [42 C.F.R. §§ 422.520(b)(1) and (2)] **See Agreement for prompt-payment provision.**
8. FDR and any related entity, contractor or subcontractor will comply with all applicable Federal and Medicare laws, regulations, and CMS instructions. [42 C.F.R. §§ 422.504(i)(4)(v)] and [42 CFR §423.505(i)(4)(iv)]
9. 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: N/A

[42 C.F.R. §§ 422.504(i)(4) and (5)]

In the event of a conflict between the terms above and the terms of a related agreement, the terms above control.