

Aetna Better Health Inc., a Louisiana corporation

Hospital Services Agreement Checklist

- _____ **All** pages of this document must be printed and returned to Aetna Better Health (not just the signature pages).
- _____ **Page 1.** The Hospital 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 Aetna Better Health.
- _____ **Page 19** must be signed by an authorized hospital representative. In addition, all information listed below the signature line (TIN, NPI, Reimbursement Address, etc) must be completed.

State Specific Information

- _____ **Provider Disclosure Statement** must be completed

- _____ **Facility Application.** The Louisiana Standard Credentialing Application must be completed and returned with the signed contract.
- _____ **Louisiana Standard Credentialing Application Additional Information Form.** This form must be completed and returned with the Facility Application
- _____ **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 19 of the Agreement.

Please return all documents to:

Attn:
Email:
Phone:

AETNA BETTER HEALTH OF LOUISIANA HOSPITAL SERVICES AGREEMENT

The term of this Medicaid Hospital Services Agreement (the "Agreement") by and between Aetna Better Health Inc., a Louisiana corporation on behalf of itself and its Affiliates (hereinafter "Company"), and _____ (hereinafter "Hospital"), shall commence effective _____, 20____ [Date to be completed by Company] (the "Effective Date"). The Medicaid/CHIP Regulatory Compliance Addendum attached to this Agreement as Exhibit A, the Louisiana State Addendum attached to this Agreement as Exhibit B and the Medicare Requirements Addendum attached to this Agreement as Exhibit D (including Schedule 1) are expressly incorporated into this Agreement and binding upon the Parties. Exhibit C is reserved. In the event of any inconsistent or contrary language between an Addendum and any other part of this Agreement, including but not limited to exhibits, attachments or amendments, the Parties agree that the provisions of the Addendum shall prevail as to the products to which it applies.

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, Hospital provides health care services to patients within the scope of its licensure or accreditation; and

WHEREAS, Company and Hospital mutually desire to enter into an arrangement whereby Hospital will become a Participating Provider and render health care services to Members; and

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

WHEREAS, Hospital understands and agrees that Government Sponsors or other government entities may require certain changes to the terms of this Agreement before Hospital 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 Hospital who provided the service or from a third party, except that it shall not mean a claim submitted by or on behalf of a Hospital 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) Hospital'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 Hospital 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.

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).

Hospital. Defined in first paragraph of this Agreement.

Hospital-Based Physicians. Any physician employed by Hospital, or who otherwise provides those services to Members as listed in the Services and Compensation Schedule attached hereto and made a part hereof.

Hospital Services. Defined in Section 2.1 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) Hospital's reimbursement for Hospital Services or (ii) Hospital administration.

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 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 Providers may be referred to herein more specifically as, e.g., "Participating Physicians" or "Participating Hospitals."

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

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 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.

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 Hospital and which are furnished or disclosed to Hospital 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**, including the member handbook, provider handbook and other applicable manuals and materials.

2.0 HOSPITAL SERVICES AND OBLIGATIONS

2.1 Provision of Services.

Hospital will make available and provide to Members Covered Services, including facilities, equipment, personnel or other resources necessary to provide such Covered Services according to generally accepted standards of hospital practice ("Hospital Services"). Upon written notice from Hospital, Company may agree to add new or relocating facilities and locations to existing Agreement upon completion of applicable credentialing and satisfaction of all other requirements of Company. Other demographic information may be revised upon written notice from Hospital.

2.2 Non-Discrimination and Equitable Treatment of Members.

Hospital agrees to provide Hospital Services to Members with the same degree of care and skill as customarily provided to Hospitals' patients who are not Members, according to generally accepted standards of practice. Hospital and Company agree that Members and non-Members should be treated equitably. Hospital agrees 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, medical history, color, national origin, place of residence, health status, claims experience, evidence of insurability (including conditions arising out of acts of domestic violence), genetic information, source of payment for services, cost or extent of Hospital Services required, or any other grounds prohibited by law or this Agreement and will abide by Company's cultural competency Policies. Hospital 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 Hospital, Hospital, 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 Hospital Representations.

2.4.1 General Representations. Hospital represents, warrants and covenants, as applicable, that: (a) it is, and will remain throughout the term of this Agreement, accredited by The Joint Commission or the Bureau of Hospitals of the American Osteopathic Association; (b) it is, 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, false claims and prohibition of kickbacks; (c) it is certified to participate in the Medicaid and Medicare programs; with such accreditation or participation applicable to all Hospital Services; (d) all Hospital-Based Physicians are properly credentialed, privileged, and re-appointed within the scope of their specialty; (e) all ancillary health care personnel employed by, associated or contracted with Hospital who treat Members (“Ancillary Personnel”): (i) are and will remain throughout the term of this Agreement appropriately licensed and/or certified (when and as required by state law) and supervised, and qualified by education, training and experience to perform their professional duties; and (ii) will act within the scope of their licensure or certification, as the case may be; (f) Hospital’s credentialing, privileging, and re-appointment procedures are in accordance with its medical staffs by-laws, regulations, and policies, comply with The Joint Commission standards, meet the querying and reporting requirements of the National Practitioner Data Bank (“NPDB”) and Healthcare Integrity and Protection Data Bank (“HIPDB”), and fulfill all applicable state and Federal standards; (g) this Agreement has been executed by its duly authorized representative; and (h) executing this Agreement and performing its obligations hereunder shall not cause Hospital to violate any term or covenant of any other agreement or arrangement now existing or hereinafter executed.

2.4.2 Government Program Representations. Company has or shall seek contracts to serve beneficiaries of Government Programs. To the extent Company participates in such Government Programs, Hospital agrees, on behalf of itself and any subcontractors of Hospital acting on behalf of Hospital, to be bound by all rules and regulations of, and all requirements applicable to, such Government Programs. Hospital acknowledges and agrees that all provisions of this Agreement shall apply equally to any employees, independent contractors and subcontractors of Hospital who provide or may provide Covered Services to Members of Government Programs, and Hospital represents and warrants that Hospital 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, Hospital acknowledges that compensation under this Agreement for such Members constitutes receipt of Federal funds. Hospital agrees that all services and other activities performed by Hospital under this Agreement will be consistent and comply with the obligations of Company and/or Government Sponsor under its contract(s) with the Centers for Medicare and Medicaid Services (“CMS”), and any applicable state regulatory agency, to offer Government Program. Hospital further agrees to allow Government Sponsor, CMS, any applicable state regulatory agency, and Company to monitor Hospital’s performance under this Agreement on an ongoing basis in accordance with Medicare/Medicaid laws, rules and regulations. Hospital acknowledges and agrees 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 Program in a manner consistent with applicable laws, rules and regulations, and that if any such activity or responsibility is delegated by Company to Hospital, the activity or responsibility may be revoked if Government Sponsor, CMS or Company determine that Hospital has not performed satisfactorily. Upon request, Hospital 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 Hospital generates and/or compiles and provides any data to Company that Company, in turn, submits to CMS, Hospital certifies, to the best of its knowledge and belief, that such data is accurate, complete and truthful.

2.4.3 Government Program Requirements. Hospital, on behalf of itself and each Hospital-Based Physician, hereby agrees to perform its obligations under this Agreement in accordance with the terms and conditions set forth in Exhibit A.

2.4.4 Qualified Providers. Hospital shall exclude any physician or other provider from performing services in connection with this agreement if such provider has been suspended or terminated from participation in Government Programs or any other government-sponsored program, including Medicare or the Medicaid program in any state. Hospital 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. Hospital further agrees that Company has the right to audit any Offshore Entity prior to the provision of services for Plans.

2.4.5 Suspension or Debarment. Hospital represents, warrants and covenants, as applicable, that it and each Hospital-Based Physician:

- 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, Medicare or the Medicaid program in any state; 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 the Agreement.

2.5 Hospital's Insurance.

During the term of this Agreement, Hospital 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 Hospital in the state or region in which the Hospital operates. Such insurance coverage shall cover the acts and omissions of Hospital as well as those Hospital's agents and employees. Hospital agrees to deliver certificates of insurance or other documentation as appropriate to show evidence of such coverage to Company upon request. Hospital 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.

2.6 Product Participation.

Hospital agrees to participate in the Plans and other health benefit programs listed on the **Program Participation Schedule**. Company reserves the right to introduce and designate Hospital's participation in new Plans, Specialty Programs and other programs during the term of this Agreement and will provide Hospital 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, Hospital agrees to comply with and participate in such program.

Nothing herein shall require that Company identify, designate or include Hospital as a preferred participant in any specific Plan for which Company provides incentives based upon the use of selected Participating Hospitals, Specialty Program or other program; provided, however, Hospital 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 Hospital has agreed to participate hereunder.

2.7 Consents to Release Medical Information.

Hospital covenants that it will obtain from Members to whom Hospital 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.

3.0 COMPANY OBLIGATIONS

3.1 Company's Covenants.

Company or Government Sponsors shall provide Members with a means to identify themselves to Hospital (e.g., identification cards), explanation of provider payments, a general description of products, a listing of Participating Providers, and timely notification of material changes in this information. Company shall provide Hospital with a means to check eligibility. Company shall include Hospital in the Participating Provider directory or directories for the Plans, Specialty Programs and products in which Hospital is a Participating Provider, including when Hospital is 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"). Hospital agrees that all Company obligations to perform, and all rights of Hospital, 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 Hospital Obligation to Submit Claims. Hospital agrees to submit Clean Claims to Company for Hospital Services rendered to Members. Hospital 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, Hospital certifies that any such data is accurate, complete and truthful. Hospital represents that, where necessary, it has obtained signed assignments of benefits authorizing payment for Hospital Services to be made directly to Hospital. Hospital will make best commercial efforts to submit a minimum of eighty-five percent (85%) of its Member claims electronically to Company. For claims Hospital submits electronically, Hospital 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. Hospital agrees that Company, or the applicable Government Sponsor, will not be obligated to make payments for billings received more than one hundred and twenty (120) days (or such other period required by applicable state law or regulation) from (a) the date of service or, (b) when Company is the secondary payer, from the date of receipt of the primary payer's explanation of benefits. Company may waive this requirement if Hospital provides notice to Company, along with appropriate evidence, of other extraordinary circumstances outside the control of Hospital that resulted in the delayed submission. In addition, unless Hospital notifies Company of its payment disputes within one hundred eighty (180) days, or such other time 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 Hospital does not timely bill Company or Government Sponsors, or dispute any payment, timely as provided in this Section 4.1.1, Hospital's claim for payment will be deemed waived and Hospital will not seek payment from Government Sponsors, Company or Members. Hospital shall pay on a timely basis all Participating Providers, employees, independent contractors and subcontractors who render Covered Services to Members of Company's Plans for which Hospital is financially responsible pursuant to this Agreement.

Hospital agrees to permit claim editing to the primary procedure those services considered part of, incidental to, or inclusive of the primary procedure and 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 Hospital is billing on a CMS 1500, 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 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.

In circumstances where the compensation under this Agreement is intended to include the services of Hospital-Based Physicians, Hospital shall be financially responsible for payment to all Hospital-Based Physicians who render Covered Services to Members and such Hospital-Based Physicians shall look solely to Hospital for payment. Notwithstanding, Company reserves the right to pay any Hospital-Based Physician for Covered Services for which Hospital 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 Hospital has engaged in a pattern of late payments in the past. If Hospital cannot resolve the claims submitted by the Hospital-Based Physicians, Company has the right to recoup other amounts owed in order to recover from Hospital any money that Company has paid to the Hospital-Based Physicians.

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 Hospital or any other party, and Company will provide, at the written request of Hospital, 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 Hospital 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 Hospital for non-capitated Covered Services rendered to Members according to the lesser of (i) Hospital'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 Hospital within thirty (30) days following actual receipt; provided, further, Company must pay ninety-nine percent (99%) of all Clean Claims from Hospital within ninety (90) days following actual receipt.. Hospital 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 Hospital 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 Hospital under this Agreement.

In the event that Hospital identifies any overpayments by Company, Hospital 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 Hospital's identification of any and all such overpayments. In addition, when reporting and returning any such overpayments by Company, Hospital 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, Hospital acknowledges the financial risks to Hospital of this arrangement and has made an independent analysis of the adequacy of this arrangement. Hospital, therefore, agrees and covenants not to bring any action asserting the inadequacy of these arrangements or that Hospital 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.

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 Hospital 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 Utilization Management. The Parties agree that Company, on its behalf and on behalf of Government Sponsors, reserves the right to perform utilization management (including retrospective review) and to adjust or deny payment for the inefficient delivery of Hospital Services related to admissions, or length of stay. To facilitate timely and accurate concurrent utilization management, Hospital and Company will cooperate as necessary to facilitate on-site and/or concurrent telephonic utilization management at Hospital. Company agrees that it will not conduct retrospective review so long as Company has been provided a reasonable opportunity to conduct full and complete concurrent utilization management review in accordance with Policies while the Member was hospitalized, except where (1) Hospital, a Participating Provider or any other provider rendering care at or on behalf of Hospital, has provided inaccurate or incomplete information to Company or (2) the patient was not a known Member as of the time of the provision of care.

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 Hospital 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 Hospital. Notwithstanding anything to the contrary in this section, in no event shall Hospital 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. Hospital 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. Hospital acknowledges that Company's denial or adjustment of payment to Hospital based on Company's performance of utilization management as described in

Section 4.1.3 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. Hospital may bill or charge individuals who were not Members at the time that services were rendered.

4.3.2 Holding Members Harmless. Hospital hereby agrees 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 Hospital 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, Deductibles made in accordance with the terms of the applicable Plan. Hospital further agrees 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 Hospital and Members or persons acting on their behalf.

4.3.3 Cost Sharing Protections for Dual Eligible Members. Hospital acknowledges and agrees that Medicare Members who are also enrolled in a State Medicaid plan ("Dual Eligible Members") are not responsible for paying to Hospital 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. Hospital 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 Medicaid plan 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, Hospital 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.

Hospital agrees to accept and comply with Policies of which Hospital knows or reasonably should have known (e.g., Clinical Policy Bulletins or other Policies made available to Participating Providers). Except when a Member requires Emergency Services, Hospital agrees to comply with any applicable precertification and/or referral requirements under the Member's Plan prior to the provision of Hospital Services. Hospital 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. Hospital agrees 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 the purpose of pre-admission testing, Hospital agrees to directly provide testing or accept test results and examinations performed outside Hospital provided such tests and examinations are: (a) performed by a state licensed laboratory for laboratory tests, and a licensed physician for such other tests and examinations; and (b) performed within a time reasonably proximate to the admission. For those Members who require services under a Specialty Program, Hospital agrees to work with Company in transferring the Member's care to a Specialty Program Provider, as the case may be. Company may at any time modify Policies. Company will provide notice by letter, newsletter, electronic mail or other media, of Material Changes. Failure by Hospital to object in writing to any Material Change within thirty (30) days following receipt thereof constitutes Hospital's acceptance of such Material Change. In the event that Hospital reasonably believes that a Material Change is likely to have a material adverse financial impact upon Hospital, Hospital 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 Hospital, 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. Hospital agrees 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 Hospital Services.

5.2 Notices and Reporting.

To the extent neither prohibited by law nor violative of applicable privilege, Hospital agrees to provide notice to Company, and shall provide all information reasonably requested by Company regarding the nature, circumstances, and disposition, of: (a) any action taken by Hospital adversely affecting medical staff membership of Participating Physicians and other Participating Providers, whether or not such actions are reportable to NPDB or HIPDB; (b) any litigation or administrative action brought against Hospital or any of its employees, medical staff members or affiliated providers which is related to the provision of health care services and could have a material impact on the Hospital Services provided to Members; (c) any investigation initiated by The Joint Commission or any government agency or program against or involving Hospital or any of its employees, medical staff members or affiliated providers that does or could adversely affect Hospital's The Joint Commission accreditation status, licensure, or certification to participate in the Medicare or Medicaid programs; (d) any change in the ownership or management of Hospital; and (e) any material change in services provided by Hospital or licensure status related to such services, including without limitation a significant decrease in medical staff or the closure of a service unit or material decrease in beds or emergency services departments. Company and Hospital agree to be mutually committed to promoting Member safety and quality. Therefore, Hospital 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. Hospital 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 Hospital described in this Section 5.2.

5.3 Information and Records.

5.3.1 Maintenance of Information and Records. Hospital agrees (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 Hospital 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 Exhibits A, B & D, as applicable. 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. Hospital agrees that (a) Company (including Company's authorized designee) and Government Sponsors shall have access to all data and information obtained, created or collected by Hospital 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 Hospital to Members ("Records"); (c) consistent with the consents and authorizations required by Section 2.6 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. Hospital agrees 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. 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, Hospital agrees to maintain Information and Records (as those terms are defined in Section 5.3) 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. Hospital 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.

Hospital agrees 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 state or Federal 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 and vendors under contract with Company, and (iii) in the case of Hospital's 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, Hospital through its staff is encouraged to discuss Company's provider payment methodology with patients, including descriptions of the methodology under which the Hospital is paid. In addition, Hospital through its staff 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 ninety (90) days prior written notice to Hospital. This Agreement may be terminated by Hospital without cause at any time following the conclusion of the Initial Term with at least ninety (90) 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 thirty (30) 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. Notwithstanding the foregoing, the effective date of such termination may be extended pursuant to Section 6.6 herein.

6.4 Immediate Termination or Suspension.

Any of the following events shall result in the immediate termination or suspension of this Agreement by Company, upon notice to Hospital, at Company's discretion at any time: (a) the withdrawal, expiration or non-renewal of any Federal, state or local license, certificate, approval or authorization of Hospital; (b) the bankruptcy or receivership of Hospital, or an assignment by Hospital for the benefit of creditors; (c) the loss or material limitation of Hospital's insurance under Section 2.4 of this Agreement; (d) a determination by Company that Hospital's continued participation in provider networks could result in harm to Members; (e) the exclusion, debarment or suspension of Hospital from participation in any governmental sponsored program, including, but not limited to, Government Programs, Medicare or the Medicaid program in any state; (f) the indictment or conviction of Hospital for any crime; (g) the revocation or suspension of Hospital's accreditation by The Joint Commission or the Bureau of Hospitals of the American Osteopathic Association; (h) change of control of Hospital to an entity not acceptable to Company; or (i) the withdrawal, expiration or termination of the State Contract. To protect the interests of patients, including Members, Hospital will provide immediate notice to Company of any of the aforesaid events described in clauses (a) through (h), 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, Hospital and Company will cooperate as provided in this Section 6.5 and in Exhibits A, B & D, as applicable. This Section 6.5 and Exhibits A, B & D, as applicable shall survive the termination of this Agreement, regardless of the cause of termination.

6.5.1 Upon Termination. Company and Hospital desire to promote continuity of care. Accordingly, upon termination or non-renewal of this Agreement for any reason, other than termination by Company in accordance with Section 6.4 above, Hospital shall remain obligated at Company's request to provide Hospital Services to: (a) a pregnant Member in the third trimester of pregnancy, throughout the term of the Member's pregnancy; (b) any Member who is an inpatient at Hospital as of the effective date of termination until such Member's discharge or Company's orderly transition of such Member's care to another provider; and (c) any Member, upon request of such Member or the applicable Plan Sponsor, for one (1) calendar year. The terms of this Agreement, including the **Hospital Services and Compensation Schedule** shall apply to such services. Upon expiration or termination of this Agreement for any reason, other than termination by Company in accordance with Section 6.4 above, Hospital agrees to provide Hospital Services at Company's discretion to any Member who is an inpatient at Hospital as of the effective date of termination until such Member's discharge or Company's orderly transition of such Member's care to another provider and as otherwise required by applicable laws, government authorities or Government Sponsor directives. The terms of this Agreement, including the **Hospital Services and Compensation Schedule** shall apply to such services.

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, Hospital shall continue to provide Hospital Services to: (a) all Members for the period for which premium has been paid; and (b) Members confined as inpatients in Hospital 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, Hospital shall cooperate with Company and comply with Policies, if any, in the transfer of Members to other providers.

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 Hospital, 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 Hospital will each be solely liable for its own activities and those of its agents and employees, and neither Company nor Hospital 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. Hospital acknowledges that all Member care and related decisions are the responsibility of Hospital and its medical staff, and that Policies do not dictate or control Hospital's clinical decisions with respect to the care of Members. Hospital 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 Hospital's provision of care to Members. Company agrees to indemnify and hold harmless the Hospital 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.

Hospital consents to the use of Hospital's name 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. Hospital 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.

Hospital 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, Hospital from advising or advocating on behalf of a Member who is its 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.

Hospital agrees 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 Hospital 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 Hospital may raise issues, concerns, controversies or claims regarding the obligations of the Parties under this Agreement. Hospital 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.

8.3.1 Submission of Claim or Controversy to Arbitration. Any controversy or claim arising out of or relating to this Agreement or the breach, termination, or validity thereof, except for temporary, preliminary, or permanent injunctive relief or any other form of equitable relief, shall be settled by binding arbitration administered by the American Arbitration Association (“AAA”) and conducted by a sole Arbitrator (“Arbitrator”) in accordance with the AAA’s Commercial Arbitration Rules (“Rules”). The arbitration shall be governed by the Federal Arbitration Act, 9 U.S.C. §§ 1-16, to the exclusion of state laws inconsistent therewith or that would produce a different result, and judgment on the award rendered by the Arbitrator (the “Award”) may be entered by any court having jurisdiction thereof. A stenographic record shall be made of all testimony in any arbitration in which any disclosed claim or counterclaim exceeds \$250,000. An Award for \$250,000 or more shall be accompanied by a short statement of the reasoning on which the Award rests.

8.3.2 Appeal of Arbitration Award. In the event a Party believes there is a clear error of law and within thirty (30) days of receipt of an Award of \$250,000 or more (which shall not be binding if an appeal is taken), a Party may notify the AAA of its intention to appeal the Award to a second Arbitrator (the “Appeal Arbitrator”), designated in the same manner as the Arbitrator except that the Appeal Arbitrator must have at least twenty (20) years’ experience in the active practice of law or as a judge. The Award, as confirmed, modified or replaced by the Appeal Arbitrator, shall be final and binding, and judgment thereon may be entered by any court having jurisdiction thereof. No other arbitration appeals may be made.

8.3.3 Confidentiality. Except as may be required by law or to the extent necessary in connection with a judicial challenge, permitted appeal, or enforcement of an Award, neither a Party nor an arbitrator may disclose the existence, content, record, status or results of a negotiation or arbitration. Any information, document, or record (in whatever form preserved) referring to, discussing, or otherwise related to a negotiation or arbitration, or reflecting the existence, content, record, status, or results of a negotiation (“Negotiation Record”) or arbitration (“Arbitration Record”), is confidential. The arbitration hearing shall be closed to any person or entity other than the arbitrator, the parties, witnesses during their testimony, and attorneys of record. Upon the request of a Party, an arbitrator may take such actions as are necessary to enforce this Section 8.3.3, including the imposition of sanctions.

8.3.4 Pre-hearing Procedure for Arbitration. The Parties will cooperate in good faith in the voluntary, prompt and informal exchange of all documents and information (that are neither privileged nor proprietary) relevant to the dispute or claim, all documents in their possession or control on which they rely in support of their positions or which they intend to introduce as exhibits at the hearing, the identities of all individuals with knowledge about the dispute or claim and a brief description of such knowledge, and the identities, qualifications and anticipated testimony of all experts who may be called upon to testify or whose report may be introduced at the hearing. The Parties and Arbitrator will make commercially reasonable efforts to conclude the document and information exchange process within sixty (60) calendar days after all pleadings or notices of claims have been received. At the request of a Party in any arbitration in which any disclosed claim or counterclaim exceeds \$250,000, the Arbitrator may also order pre-hearing discovery by deposition upon good cause shown. Such depositions shall be limited to a maximum of three (3) per Party and shall be limited to a maximum of six (6) hours’ duration each. As they become aware of new documents or information (including experts who may be called upon to testify), all Parties remain under a continuing obligation to provide relevant, non-privileged documents, to supplement their identification of witnesses and experts, and to honor any understandings between the Parties regarding documents or information to be exchanged. Documents that have not been previously exchanged, or witnesses and experts not previously identified, will not be considered by the Arbitrator at the hearing. Fourteen (14) calendar days before the hearing, the Parties will exchange and provide to the Arbitrator (a) a list of witnesses they intend to call (including any experts) with a short description of the anticipated direct testimony of each witness and an estimate of the length thereof, and (b) premarked copies of

all exhibits they intend to use at the hearing.

8.3.5 Arbitration Award. The arbitrator may award only monetary relief and is not empowered to award damages other than compensatory damages and, in the arbitrator's discretion, pre-award interest. The Award shall be in satisfaction of all claims by all Parties. Arbitrator fees and expenses shall be borne equally by the Parties. Postponement and cancellation fees and expenses shall be borne by the Party causing the postponement or cancellation. Fees and expenses incurred by a Party in successfully enforcing an Award shall be borne by the other Party. Except as otherwise provided in this Agreement, each Party shall bear all other fees and expenses it incurs, including all filing, witness, expert witness, transcript, and attorneys' fees.

8.3.6 Survival. The provisions of Section 8.3 shall survive expiration or termination of this Agreement, regardless of the cause giving rise hereto.

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

Company and Hospital agree that 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 hereto and no changes, amendments or alterations 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 Hospital to object in writing to any such Amendment within thirty (30) days following receipt thereof constitutes Hospital's acceptance of such Amendment. In the event that Hospital reasonably believes that an Amendment is likely to have a material adverse impact upon Hospital, Hospital 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 Hospital, 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. Hospital agrees 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 Hospital 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. Hospital 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 where Hospital is located.

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 Hospital Services by Hospital and does not apply to any other organization which succeeds to Hospital assets, by merger, acquisition or otherwise, or is an affiliate of Hospital. 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 Hospital.

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). Hospital shall notify Company of any changes in the information provided by Hospital related to Hospital'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 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 Hospital.

9.11 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 9.11 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.

9.12 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.

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

HOSPITAL

Hospital Sign Here

COMPANY

By: _____

By: _____

Printed Name: _____

Printed Name: _____

Title: _____

Title: _____

Date: _____

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 Hospital at:

To Company at:

As of the date of execution of this Agreement, Company is not yet able to identify the “notices” address that will be in effect as of the Effective Date of this Agreement. The Parties understand and agree that, on or prior to the Effective Date of this Agreement, Company will provide Hospital with such “notices” address by letter, newsletter, electronic mail or other media. Notwithstanding any other provision of Section 9.8 to the contrary, Company shall not be required to provide such address information by overnight delivery service with proof of receipt, or by certified mail return receipt requested.

PROGRAM PARTICIPATION SCHEDULE

Hospital agrees to participate in the Plans and other health benefit programs listed herein upon issuance of any required licenses and contracts to Company:

Those Louisiana Medicaid and CHIP Plans and programs offered by Company within the State of Louisiana. Includes Bayou Health, Managed Long Term Services and Supports, Behavioral Health. Basic Health Plans, Bridge Plans or other health plans offered to Medicaid-eligible enrollees.

Those Medicare plans for Medicaid enrollees offered by Company within the State of Louisiana. 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 Louisiana.

SERVICES AND COMPENSATION SCHEDULE

1.0 COMPENSATION

Louisiana Medicaid, CHIP & QHP Plans: Aetna Medicaid Market Fee Schedule

Louisiana Medicare Plans: 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 Louisiana's 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, Hospital must designate applicable codes related to those Covered Services provided by Hospital 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-9 (or successor standard) Diagnosis and Procedure codes, 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.

The use of ICD-10 coding shall not impact the aggregate rates and compensation intended by the Parties as set forth in this Services and Compensation Schedule. Consequently, in the event that use of ICD-10 codes result in aggregate payments that would differ from the aggregate payments that would have resulted based on ICD-9 coding (excluding utilization and validated case mix severity changes), the rates set forth in this Services and Compensation Schedule will be reviewed by Company periodically and adjusted at least annually in order to reflect what would have been paid had ICD-9 coding been utilized for determination of the payments.

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 Louisiana 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 Hospital meets the requirements of applicable law for the rates, Company shall compensate Hospital 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 Hospital's billed charges or an amount equal to but not greater than the State's enhanced rates. Hospital 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 Hospital 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.

Exhibit A

Louisiana Medicaid/CHIP Compliance Addendum

This Regulatory Compliance Addendum is incorporated by reference in the Agreement. It applies to Medicaid and CHIP products, including the Bayou Health Program and the eligible populations covered by the State Contract. This **Exhibit A** is effective as of the Effective Date of the Agreement.

If there is any conflict between the terms of this **Exhibit A** and any of the other terms of this Agreement, including any attachments, schedules, exhibits and/or addenda made part of this Agreement, the terms of this **Exhibit A** will govern and control; provided, however, if there is any conflict between any of the terms of this Agreement, including this **Exhibit A**, and the State Contract, then the terms of the State Contract will govern and control. For purposes of this Regulatory Compliance Addendum, the term “Provider” shall mean the health care physician, provider, group, facility or hospital executing this Agreement, as identified on the first page of the Agreement.

1. DEFINITIONS

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

Bayou Health (or Bayou Health Program). The full risk-bearing MCO health care delivery system, authorized by La. R.S. 36:254 and operated by DHH under the authority of the State Plan Amendment, responsible for providing specified Medicaid core benefits and services included in the Louisiana Medicaid State Plan to Medicaid recipients.

Behavioral Health Services (“BHS”). Mental health and substance abuse services, which are provided to Enrollees with emotional, psychological, substance abuse, psychiatric symptoms and/or disorders. BHS may be basic or specialized. Basic BHS are provided in the Enrollee’s PCP office by the Enrollee’s PCP as part of primary care service activities, as well as those services provided in an FQHC (“Federally Qualified Health Center”). Specialized mental health services shall include, but not be limited to, services specifically defined in the Medicaid State Plan (or as otherwise authorized by the Bayou Health program) and provided by a psychiatrist, psychologist, and/or mental health rehabilitation provider to those Enrollees with a primary diagnosis of a behavioral disorder.

Children’s Health Insurance Program (“CHIP”). The program created in 1997 by Title XXI of the Social Security Act and known in Louisiana as CHIP.

Claim. In addition to the provisions of this Agreement, Claim means (1) a bill or services, (2) a line item of service or (3) all services for one recipient within a bill.

Clean Claim. A Clean Claim means one that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a Claim with errors originating in a State’s Claims system. It does not include a Claim from a provider who is under investigation for fraud or abuse, or a Claim under review for medical necessity.

Covered Services. Those health care services/benefits to which an individual eligible for Medicaid/CHIP is entitled under the Louisiana Medicaid State Plan.

Emergency Services. Covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish these services under 42 C.F.R. § 438.114(a) and Section 1932(b)(2) of the Social Security Act and that are needed to screen, evaluate and stabilize an emergency medical condition. Services defined as such under Section 1867(e) of the Social Security Act (“anti-dumping provisions”). If an emergency medical condition exists, the MCO is obligated to pay for the Emergency Service. Coverage of Emergency Services must not include any prior authorization requirements, and the “prudent layperson” standard shall apply to both in-plan and out-of-plan coverage.

Enrollee. A Louisiana Medicaid or CHIP recipient who is currently enrolled in an MCO or other Medicaid managed care program.

Louisiana Department of Health and Hospitals (“DHH”). The state department responsible for promoting and protecting health and ensuring access to medical, preventive and rehabilitative services for all citizens in the state of Louisiana.

Louisiana Medicaid State Plan. The binding written agreement between DHH and CMS, which describes how the Medicaid program is administered and determines the services for which DHH will receive federal financial participation.

Managed Care Organization (“MCO”). A private entity that contracts with DHH to provide core benefits and services to Enrollees in exchange for a monthly prepaid capitated amount per Member. The entity is regulated by the Louisiana Department of Insurance with respect to licensure and financial solvency, pursuant to La. R.S. 22:1016, but shall, solely with respect to its products and services offered pursuant to the Louisiana Medicaid program be regulated by DHH.

Managed Care Program. The Louisiana Medicaid program providing statewide leadership to most effectively utilize resources to promote the health and well-being of Enrollees in DHH’s Bayou Health Program.

Material Changes. Material changes are changes affecting the delivery of care or services provided under the State Contract. Material changes include, but are not limited to, changes in composition of the provider network, subcontractor network, the MCO’s complaint and grievance procedures; health care delivery systems, services, changes to expanded services; benefits; enrollment of a new population; procedures for obtaining access to or approval for health care services; any and all policies and procedures that require DHH approval prior to implementation; and the MCO’s capacity to meet minimum enrollment levels. DHH shall make the final determination as to whether a change is material..

Medicaid. A means tested federal-state entitlement program enacted in 1965 by Title XIX of the Social Security Act Amendment. Medicaid offers federal matching funds to states for costs incurred in paying health care providers for serving covered individuals.

Medical Record. A single complete record kept at the site of the Member's treatment(s), which documents medical or allied goods and services, including, but not limited to, outpatient and emergency medical health care services whether provided by the MCO, its subcontractor or any out-of-network providers. The records may be electronic, paper, magnetic material, film or other media. In order to qualify as a basis for reimbursement, the records must be dated, legible and signed or otherwise attested to, as appropriate to the media, and meet the requirements of 42 C.F.R. § 456.111 and 42 C.F.R. § 456.211.

Medically Necessary or Medical Necessity. Those health care services that are in accordance with generally accepted, evidence-based medical standards or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care. In order to be considered medically necessary, services must be: (1) deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain or have resulted or will result in a handicap, physical deformity or malfunction; and (2) 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. Any such services must be clinically appropriate, individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the recipient requires at that specific point in time. Services that are experimental, non-FDA approved, investigational, or cosmetic are specifically excluded from Medicaid coverage and will be deemed “not medically necessary.” Additionally, the Medicaid director, in consultation with the Medicaid medical director, may consider authorizing services at his discretion on a case-by-case basis.

Member. As it relates to the Louisiana Medicaid/CHIP programs, the State Contract and this Agreement, Member refers to a Medicaid/CHIP eligible who enrolls in an MCO under the provisions of the State Contract and also refers to an “Enrollee” as defined in 42 C.F.R. § 438.10(a).

Policies. In addition to the policies and procedures promulgated by Company, which relate to the duties and obligations of the Parties under the terms of this Agreement, Policies include the general principles by which DHH is guided in its management of the Title XIX program, as further set forth and defined by DHH promulgations and by state and federal rules and regulations.

Post-Stabilization Care Services. Covered Services relating to an Emergency Medical Condition that are provided after a Member is stabilized in order to maintain, improve or resolve the Member's condition, pursuant to 42 C.F.R. § 422.113(c)(1) and § 438.114.

Primary Care Provider ("PCP"). An individual physician, nurse practitioner or physician assistant who accepts responsibility for the management of a Member's health care. The Primary Care Provider is the patient's point of access for preventive care or an illness and may treat the patient directly, refer the patient to a specialist (secondary/tertiary care) or admit the patient to a hospital.

State Contract. The written agreement between Company and DHH, the Government Sponsor, a copy of which shall be furnished to Provider upon request. The State Contract is comprised of and incorporates all provisions of the RFP and any addenda, appendices, attachments or amendments thereto, as well as any member handbook, provider handbook and/or other applicable policy guides, manuals and materials.

2. PROVIDER SERVICES AND OBLIGATIONS

2.1 Licensing Requirements. Provider must be currently licensed and/or certified under applicable state and federal statutes and regulations and shall maintain, throughout the term of this Agreement, all necessary licenses, certifications, registrations and permits as are required to provide Covered Services or perform other activities delegated by Company. If DHH or Company discovers that Provider is not properly licensed by the appropriate authority, Provider shall immediately discontinue providing services to Members. Upon proper licensing by the appropriate authority and approval by DHH, Company may reinstate Provider to provide services to Members.

2.2 Suspension or Debarment. Provider acknowledges and understands that Company shall not execute contracts with any provider who has been excluded from participation in the Medicare and/or Medicaid programs pursuant to § 1128 (42 U.S.C. § 1320a-7) or § 1156 (42 U.S.C. § 1320 c-5) of the Social Security Act or who are otherwise barred from participation in the Medicaid and/or Medicare programs. Provider further acknowledges that Company is prohibited from entering into any relationship with anyone debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from non-procurement activities under regulations issued under Executive Orders.

2.3 Provider Services Requirements. Provider must provide, or arrange for the provision of, Covered Services or coverage of core benefits and services in the amount, duration and scope of core benefits and services specified in the Louisiana Medicaid State Plan, as well as all specific requirements of the State Contract, services under this Agreement to Members through the last day that this Agreement is in effect. Provider acknowledges that all final Medicaid benefit determinations are within the sole and exclusive authority of DHH or its designee.

2.4 Fraud and Abuse Policies. To the extent applicable, Provider, on behalf of itself and any subcontractors, agrees to comply with applicable provisions of the State Contract and Company's Fraud and Abuse Compliance Plan or other compliance program developed by Company to prevent, reduce, detect, correct and report known or suspected fraud, waste and abuse in the administration and delivery of health care services. Provider shall abide by all requirements of the State Contract regarding right of review and recovery by Company and DHH for possible acts of fraud, waste and abuse for services under this Agreement, including those rules governing complex reviews and potential overpayments and/or underpayments.

2.5 Byrd Anti-Lobbying Amendment. Provider further agrees to comply with the Byrd Anti-Lobbying Amendment, which provides that contractors who apply or submit bids shall file the required certification that each tier will not use federal funds to pay a person or employee or organization for influencing or attempting to influence an officer or employee of any federal agency, a member of Congress, officer or employee of Congress or an employee of a member of Congress in connection with obtaining any federal contract, grant or any other award covered by 31 U.S.C. § 1352. Each tier shall also disclose any lobbying with nonfederal funds that takes place in connection with obtaining any federal award. Such disclosures are forwarded from tier to tier, up to the recipient (45 C.F.R. § 3).

2.6 Referrals. Provider shall adhere to Company's referral system and guidelines to ensure that services are furnished to Enrollees promptly and without compromise to care. Provider agrees to cooperate with Company with requested reporting and monitoring activities regarding referrals and ensure that documentation of specialty health care and out-of-network referrals, services and follow-up activities are included in the Medical Record maintained by the Member's PCP. Provider

also agrees to adhere to Company's procedures and criteria for making referrals and coordinating care with behavioral health providers and agencies that will promote continuity, as well as, cost-effective care.

2.7 Responsibilities of Primary Care Providers. If Provider is a PCP, the PCP shall serve as the member's initial and most important point of interaction. The PCP shall also be responsible for the following:

- (a) Managing and coordinating the medical and health care needs of members to assure that all Medically Necessary services are made available in a timely manner;
- (b) Referring patients to subspecialist and subspecialty groups and hospitals as they are identified for consultation and diagnostics according to evidence-based criteria for such referrals as it is available;
- (c) Communicating with all other levels of medical care to coordinate and follow-up the care of individual patients;
- (d) Providing the coordination necessary for the referral of patients to specialists and for the referral of patients to services that may be available through Medicaid fee-for-service ("FFS");
- (e) Maintaining a medical record of all services rendered by the PCP and record of referral to other providers and any documentation provided by the rendering provider to the PCP for follow-up and/or coordination of care;
- (f) Development of a plan of care to address risks and medical needs and other responsibilities regarding care management as set forth in Company Policies and the State Contract;
- (g) Ensuring that in the process of coordinating care, each Enrollee's privacy is protected consistent with the confidentiality requirements of state law and those set forth in 45 C.F.R. Parts 160 and 164, which set forth the requirements regarding the privacy of individually identifiable health information;
- (h) Providing after-hours availability to patients who need medical advice. At a minimum, PCP offices must have a return call system staffed and monitored in order to assure that the member is connected to a designated medical practitioner within thirty (30) minutes of the call;
- (i) Maintaining hospital admitting privileges or arrangements with a physician who has admitting privileges at an MCO participating hospital; and
- (j) Provide basic BHS and refer Members to the appropriate health care specialist as deemed necessary for specialized BHS.

2.8 Medically Necessary/Preventive Services. Provider may not refuse to provide medically necessary or covered preventive services to Members covered under this Agreement or the State Contract for non-medical reasons (except those services allowable under federal law for religious or moral objections). However, Provider is not required to accept or continue treatment of a patient with whom Provider feels he/she cannot establish and/or maintain a professional relationship.

2.9 Emergency Services. Provider shall render Emergency Services without the requirement of prior authorization of any kind. Provider agrees to cooperate with Company's obligations to monitor utilization of Emergency Services and correct inappropriate emergency department utilization.

2.10 Laboratory Services. If Provider performs laboratory services, Provider must meet all applicable federal and state law requirements, including the provisions of 42 CFR § 493.1 and § 493.3.

2.11 Behavioral Health Services. DHH and Company support the integration of physical services and BHS through screening and strengthening prevention/early intervention at the primary care level of care. As applicable, Provider shall utilize behavioral health screening tools and protocols consistent with industry standards. PCP and Company shall collaborate with behavioral health specialists, including but not limited to, psychiatrists, psychologists, licensed clinical social workers, licensed professional counselors, mental health clinics, mental health rehabilitation service providers (public or private) and other specialty behavioral health providers, to ensure the provision of services to Members as specified in the Medicaid State Plan. In addition, Provider is not permitted to encourage or suggest, in any way, that Members be placed in state custody to receive medical or specialized BHS covered by DHH.

2.12 Treatment Decisions. Provider shall be familiar with the package of benefits offered by DHH set forth in the State Contract and DHH's requirement that providers make treatment decisions based upon individual medical needs. Provider must comply with DHH's requirements governing Member rights and responsibilities as set forth in State Contract, Company Policies and applicable state and federal law.

2.13 Appointment System. Provider shall abide by the appointment availability access standards for core benefits and/or expanded services, when applicable, to ensure that Members' needs are sufficiently met. Provider shall ensure that appointments are on a timely basis, as follows:

- (a) Routine, non-urgent or preventive care visits scheduled within six (6) weeks;
- (b) Urgent care visits within twenty-four (24) hours. Provider must provide or make arrangements, as directed by Company or through other arrangements, for a patient to obtain urgent care twenty-four (24) hours per day, seven (7) days per week;
- (c) Emergent or emergency visits immediately upon presentation at a service delivery site. Emergency Services must be available at all times;
- (d) Non-urgent sick care within seventy-two (72) hours or sooner if medical condition(s) deteriorates into an urgent or emergency condition;
- (e) In office waiting times for scheduled appointments should not routinely exceed forty-five (45) minutes, including time in the waiting room and examining room. If Provider is delayed, patients shall be notified immediately. If the wait is anticipated to be more than ninety (90) minutes, the patient shall be offered a new appointment;
- (f) Maternity Care:
 - (i) Initial appointment for prenatal visits for newly enrolled pregnant women, who must be treated without unreasonable delay, shall meet the following timetables from the postmark date the MCO mails the member's welcome packet:
 - (1) In the first trimester within fourteen (14) days;
 - (2) In the second trimester within seven (7) days;
 - (3) In the third trimester within three (3) day;
 - (ii) High risk pregnancies within three (3) days of identification of high risk by Company or maternity care provider, or immediately if an emergency exists;
- (g) Specialty care consultation within one (1) month of referral or as clinically indicated;
- (h) Lab and X-ray services (usual and customary) not to exceed three (3) weeks for regular appointments and forty-eight (48) hours for urgent care or as clinically indicated;
- (i) Follow-up to emergency department visits in accordance with emergency department attending provider discharge instructions;
- (j) Walk-in patients with non-urgent needs should be seen if possible or scheduled for an appointment consistent with written scheduling procedures; and
- (k) Direct contact with a qualified clinical staff person must be available through a toll-free number at all times.

2.14 Insurance. Provider shall secure and maintain throughout the term of this Agreement, all necessary, and in the amounts required by the State Contract and/or Company, liability, workers' compensation and malpractice insurance or other coverage as is necessary to adequately protect Members and Company under this Agreement. Provider shall furnish Company with written verification of the existence of such coverage at all times during this Agreement. Provider shall not commence performance under this Agreement until all insurance requirements have been obtained and approved by Company.

2.15 No Interference by Company. Subject to the limitations set forth in 42 C.F.R. § 438.102(a)(2), Company agrees that it shall not prohibit or otherwise restrict Provider, acting within the lawful scope of practice, from advising or advocating on behalf of an Enrollee who is his or her patient, regardless of whether benefits for such care or treatment are provided under the State Contract, for the following:

- (a) The Enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;
- (b) Any information the Enrollee needs in order to decide among all relevant treatment options;
- (c) The risks, benefits, and consequences of treatment or non-treatment; and
- (d) The Enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment and to express preferences about future treatment decisions.

2.16 Required Disclosures. Provider shall comply with the disclosure provisions of 42 C.F.R. § 455, Subpart B and disclose all required information regarding significant business transactions, ownership and control information to Company, as well as otherwise required by applicable law.

2.17 Training. Provider shall participate in training sessions provided by Company to ensure that Provider, and any subcontractors, adhere to Company policies and procedures and Medicaid regulations, including all restrictions and limitations on marketing guidelines.

2.18 Covered Population. Provider shall provide services to the enrollment populations identified in and in accordance with the State Contract, as amended from time to time.

3. CLAIMS SUBMISSION, COMPENSATION AND MEMBER BILLING

3.1 Compensation. Provider shall promptly submit accurate information needed to make payment under the terms of this Agreement, identifying the name and address of the official payee to whom payment shall be made and the method and amount of compensation. Provider shall make full disclosure of the method and amount of compensation or other consideration received from Company. In accordance with 42 CFR § 438.210(e), Provider is not compensated to provide incentives for Company to deny, limit, or discontinue medically necessary services to any Member.

3.2 Payment of Claims. Company agrees to pay 90% of all Clean Claims submitted by Provider within fifteen (15) business days of the date of receipt and 99% of all Clean Claims submitted by Provider within thirty (30) business days of the date of receipt. The date of receipt is the date that Company receives the Claim, as indicated by the date stamp on the Claim. The date of payment is the date of the check or other form of payment. Company and Provider may, by mutual agreement, establish an alternative payment schedule herein. Provider must submit all Claims for Covered Services for payment no later than one hundred and eighty (180) days from the date of service.

3.3 Capitation Arrangement Payments. With respect to payments made through a capitation arrangement, Provider shall submit all encounter data to the same standards of completeness and accuracy as required for proper adjudication of FFS Claims. If Provider becomes aware for any reason that he or she is not entitled to a PMPM payment for a particular Member (i.e., patient dies), Provider shall immediately notify both Company and DHH by certified mail, return receipt requested. Provider acknowledges and understands that such capitation arrangements may be subject to adjustment.

3.4 Timely Reimbursement. In the event that DHH deems Company unable to timely process and reimburse Claims, and requires Company to submit Claims for reimbursement to an alternate Claims processor, if applicable, to ensure timely reimbursement, Provider agrees to accept reimbursement at no more than the Company's contracted reimbursement rate or DHH's established FFS rate.

3.5 In-Network Reimbursement. Unless mutually agreed upon by the Parties, Providers who are in-network providers shall not be reimbursed by Company for defined core benefits and services at less than the Medicaid FFS rate in effect on the date of service or its equivalent (such as a DRG case rate).

3.6 Member Billing. Provider shall accept payment for Covered Services made by Company under the terms of this Agreement as payment-in-full and shall not solicit or accept any surety or guarantee of payment from DHH or any Member, which shall include the patient, parent(s), guardian, spouse or any other legally or potentially legally responsible person of the Member being served. In accordance with federal law and regulations, Provider shall not bill Members any amount greater than would be owed if Company provided the services directly. To the extent cost sharing is required of a Member, Provider shall not deny services because of the individual's inability to pay. Members shall not be held liable for the costs of any and all services not covered by Company or in cases where Provider failed to obtain required authorization.

3.7 FQHC/RHC ("Rural Health Center") Reimbursement. Company shall reimburse a contracted FQHC/RHC at an amount equal to the Prospective Payment System ("PPS") rate in effect on the date of service of each encounter. As applicable, Provider agrees and understands that Company shall not enter into alternative reimbursement arrangements with FQHCs or RHCs.

3.8 Compensation for UM Activities. In accordance with federal law and regulations, any compensation to Company, entities or individuals that conduct utilization management activities is not structured so as to provide incentives for the entity, individual or Company to deny, limit or discontinue medically necessary services to any Member.

4. COMPLIANCE WITH POLICIES

4.1 Compliance with Applicable Law. Provider agrees to recognize and abide by all state and federal laws, rules and regulations and guidelines applicable to the provision of services under the Bayou Health Program, including Title VI and VII of the Civil Rights Act of 1964, the Vietnam Era Veterans' Readjustment Assistance Act of 1974, Americans with Disabilities Act of 1990, the Rehabilitation Act of 1973, Section 202 of Executive Order 11246 and all applicable requirements imposed by or pursuant to the regulations of HHS.

4.2 Reporting Communicable Diseases. Provider shall comply with the La. Admin. Code; Sanitary Code, Title 51, Part II, Chapter 1 and La. R.S. 40:4 *et seq.* by reporting all cases of communicable diseases such as tuberculosis, sexually transmitted diseases and Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome infection to the state public health agency within twenty-four (24) hours of notification from the date of service.

4.3 QAPI and UM Programs. To the extent applicable to Provider, Provider shall adhere to the Quality Assessment and Performance Improvement Program ("QAPI") and Utilization Management ("UM") requirements specified by DHH and Company, including those set forth in the State Contract. Such requirements shall be incorporated into this Agreement.

4.4 Grievance System. Company will provide Provider with information regarding Company's grievance system that complies with state and federal laws, including 42 C.F.R. § 438, Subpart F. Provider agrees to adhere to the requirements of Company's grievance and appeals procedures. Provider shall comply with Company's Policies for grievance and appeal procedures as well as facilitate Member grievance and appeals and assist Members as required. No punitive action will be taken against any provider who files on behalf of a Member.

4.5 Record Keeping System. Provider shall maintain an adequate record system for recording services, service providers, charges, dates and all other commonly accepted information elements for Covered Services rendered to Members under the terms of this Agreement (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed). Company, Members and their representatives shall be given access to and can request copies of Members' Medical Records to the extent and in the manner provided by La. R.S. 40:1299.96 and 45 C.F.R. § 164.524 and as subject to reasonable charges.

4.6 Maintenance of Medical Records. Provider shall maintain a unified Medical Record for each Member following Company's documentation guidelines regarding medical records, and the medical record documentation guidelines set forth in the State Contract.

4.7 Record Retention Policy. All records originated or prepared in connection with Provider's performance of its obligations under this Agreement, including but not limited to, working papers related to the preparation of fiscal reports, medical records, progress notes, charges, journals, ledgers, and electronic media, will be retained and safeguarded by Provider in accordance with the terms and conditions of the State Contract and this Agreement. Provider agrees to retain all financial and programmatic records, supporting documents, statistical records and other records of Members relating to the delivery of care or service under this Agreement, and as further required by DHH, for a period of six (6) years after the last payment was made for services provided to a Member and retained further if the records are under review, audit, or related to any matter in litigation until the review, audit, or litigation is complete. If any litigation, claim or other actions involving the records have been initiated prior to the expiration of the six (6) year period, the records shall be retained until completion of the action and resolution of all issues that arise from it or until the end of the six (6) year period, whichever is later. If Provider stores records on microfilm or microfiche, Provider shall produce, at its expense, legible hard copy records upon the request of state or federal authorities, within twenty one (21) calendar days of the request.

4.8 Medicaid Records Retention. Except for Medical Records pertaining to once-in-a-lifetime events, Provider shall retain any and all Member records (financial, medical, etc.) for a period of six (6) years after the last payment was made for Covered Services provided to a Member (or any greater period of time required by applicable federal and state law) or longer if the records are under review, audit, or related to any matter in litigation until the review, audit or litigation is complete.

This requirement pertains to the retention of records for Medicaid purposes only. Other state or federal laws may require longer retention periods. Per La. R.S. 40:1299.96, providers must retain their records for at least six (6) years. These minimum record keeping periods run from the last date of treatment. After these minimum record-keeping periods, destruction of records is permitted. Provider shall ensure that any and all Member records are made available for fiscal audit, medical audit, medical review, utilization review and other periodic monitoring upon request of DHH or its authorized representative.

4.9 Access to Information and Records. Provider acknowledges and understands that state authorities, such as DHH, the State Auditor's Office and the Louisiana Attorney General's Office, shall have the right to evaluate, through audit, inspection or other means, whether announced or unannounced, any records pertinent to the State Contract and this Agreement, including documents related to the quality, appropriateness and timeliness of services and the timeliness and accuracy of encounter data and Claims submitted to Company. Such evaluation, when performed, shall be performed with the cooperation of Provider. Upon request, Provider shall assist in such review.

4.10 Program Procedures. Provider agrees to participate and cooperate in any internal and external quality assessment review, utilization management and grievance procedures established by Company, DHH and/or its designee. Provider further agrees to comply with all limitations on Provider marketing and any corrective action plan initiated by Company and/or required by DHH. Provider shall monitor and report the quality of services provided under this Agreement and, if necessary, initiate a plan of correction to improve the quality of care in accordance with that level of care which is recognized as acceptable professional practice in Provider's community and/or the standards established by Company, DHH and/or its designee.

4.11 Reports to Company. Provider shall provide and cooperate with Company to provide all reports and clinical information required for reporting purposes, including but not limited to, HEDIS, AHRQ, EPSDT, etc.

4.12 Member Information. Provider shall safeguard Member information in accordance with applicable state and federal laws and regulations and the policies and safeguards established by Company.

4.13 Notice of Legal or Administrative Actions. Provider shall provide Company with immediate notification in writing by certified mail of any litigation, investigation, administrative legal action, complaint, claim or transaction that may reasonably be considered to have a material impact on Provider's ability to provide services under this Agreement. Provider shall also provide prompt notice of any claim made against Provider by a third party, including a Member, that may result in litigation related in any way to Company's State Contract with DHH.

4.14 Reporting of Births. To the extent applicable and if Provider is a hospital, Provider must report the births of newborns within twenty-four (24) hours of birth for enrolled Members using DHH's web-based Facility Notification System.. If Provider is a hospital, Provider shall accurately register all births through the Louisiana Electronic Event System ("LEERS") administered by DHH/Vital Records Registry.

4.15 Records Upon Termination. Company and Provider recognize and agree that in the event of termination of the State Contract between Company and DHH, Provider shall immediately make available to Company or its designated representative and to DHH or its designated representative, in a usable form, any and all records, whether medical or financial, related to Company's and Provider's activities undertaken pursuant to this Agreement. The provision of such records shall be at no expense to DHH.

4.16 Failure to Comply with Contractual or Credentialing Requirements. In the event Provider fails to comply with specific contractual and/or credentialing requirements as set forth in this Agreement or Company Policies, Provider may be subject to monetary penalties, sanctions or reductions in payment, which shall include, but may not be limited to Provider's failure or refusal to respond to Company's request for information, the request to provide medical records, credentialing information, etc. Penalties shall be imposed at the Company's discretion or by a directive of DHH that Company impose, at a minimum, financial consequences against Provider as appropriate.

4.17 Assistance to Members. In accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d, *et seq.*) and 45 C.F.R. Part 80, Provider must take adequate steps, including coordination with Company, to ensure that persons with

limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under this Agreement.

4.18 PCP Linkages. If Provider is a PCP, the maximum number of linkages that Company may link to PCP is _____. By signing this Agreement, PCP confirms that his/ her total number of Medicaid Members shall not exceed 2,500 Medicaid/CHIP lives. Non-compliance with this provision may result in sanctions, including, but not limited to, financial sanctions, transfer of Members to another PCP within the Company or termination of this Agreement.

4.19 Coding Requirements. Provider shall follow Company's requirements and guidelines for Claims coding and processing that are specific to each provider type. Company shall notify Provider ninety (90) days before implementing changes to Claims coding and processing guidelines applicable to Provider. The State and HHS may inspect and audit any financial records of Company, Provider or its subcontractors. There shall be no restrictions on the right of the state or federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness or timeliness of services and reasonableness of their costs.

4.20 Encounter Data. If Company has entered into a capitated reimbursement arrangement with Provider under the terms of this Agreement, Provider shall submit to Company all encounter data in a manner consistent with the same standards of completeness and accuracy as required for proper adjudication of FFS Claims by Company.

5. TERM AND TERMINATION

5.1 Termination for Failure to Re-credential. Provider shall be subject to re-credentialing by Company during the term of this Agreement. If Provider fails to submit all appropriate documents for re-credentialing as required under this Agreement or if Provider's re-credentialing materials are not received by Company, this Agreement may be terminated within thirty (30) days of expiration of Provider's current credentialing.

5.2 Termination for Cause. The Parties agree and understand that if this Agreement is terminated for cause, the effective date of such termination may be extended to provide adequate notice to DHH, or to otherwise comply with the requirements of the State Contract or applicable law.

5.3 Immediate Termination. Company may terminate this Agreement immediately at any time upon the following events:

- (a) Provider's actions or the actions of Provider's subcontractor(s) pose a serious threat to the health of Members enrolled with Company;
- (b) In the event DHH determines that Company has become financially unstable and terminates the State Contract between Company and DHH; and
- (c) Provider fails to disclose any ownership changes within thirty-five (35) calendar days as required by 42 C.F.R. § 455.104.

5.4 Termination Without Cause. Either Party may terminate this Agreement without cause by providing ninety (90) days advance written notice to the other Party; however, such shorter periods as applicable under state law and/or the Bayou Health Program to Provider, where Provider is not a group or hospital.

6. GENERAL PROVISIONS

6.1 Disputes. Company and Provider shall be responsible for resolving any disputes that may arise between the Parties. The Parties agree that no dispute shall disrupt or interfere with the provisions of services to Members.

6.2 No Assignment. Provider shall not assign any of its duties and/or responsibilities under this Agreement and the State Contract without the prior written consent of MCO.

6.3 Incorporation of Changes to Laws and Regulations. This Agreement incorporates by reference all applicable federal and state laws or regulations, and revisions of such laws or regulations shall automatically be incorporated into this Agreement as they become effective. In the event that these changes or the result of such revisions to applicable federal or state law materially affect the position of either Party, Company and Provider agree to negotiate such further amendments as may be necessary to correct any inequities.

6.4 Modifications and Amendments. No modification, alteration, variation, waiver, extension of termination date, early termination of this Agreement or change of any provision of this Agreement shall be made unless such modification is reduced to writing, duly signed and attached as a written amendment to this Agreement; however, Company may provide amendments by written notification through Company bulletins, if mutually agreed to by the Parties and with prior notice to DHH.

If the modification or change constitutes a Material Change affecting Company's ability to deliver or administer health care services, prior approval is required by DHH of at least thirty (30) days in advance of the proposed change implementation. Notwithstanding the foregoing, the Parties acknowledge that this Agreement has been executed based upon a draft of the State Contract and related materials and that the provisions of such documents may be revised prior to the Effective Date. This Agreement shall be automatically amended to conform to the terms and provisions of the final State Contract and related materials. In the event of any inconsistency between the terms of this Agreement and the terms of the final requirements for provider agreements as set forth in the final State Contract and related materials, the terms of the final State Contract and the Policies shall control and take precedence.

6.5 Entire Agreement. This Agreement, including the State Contract, any DHH guidance or materials, schedules, appendices, exhibits and/or addenda (which may be provided upon request), constitutes the complete and sole contract, and all terms and conditions, 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.

6.6 Non-Discrimination. Provider and Company agree that no person, on the grounds of handicap, age, race, color, religion, sex, sexual orientation, national origin or basis of health status or need for health care services shall be excluded from participation in, or be denied benefits of the Government Program administered by Company. Provider shall post notices of non-discrimination in conspicuous places, available to all employees and applicants.

6.7 Indemnification and Hold Harmless. Unless Provider is a state agency, Provider shall indemnify, defend, protect and hold harmless DHH and any of its officers, agents and employees from:

- (a) Any claims for damages or losses arising from services rendered by any contractor, person or firm performing or supplying services, materials or supplies for Provider in connection with the performance of this Agreement;
- (b) Any claims for damages or losses to any person or firm injured or damaged by erroneous or negligent acts, including disregard of state or federal Medicaid regulations or legal statutes, by Provider, its agents, officers, employees or contractors in the performance of this Agreement;
- (c) Any claims for damages or losses resulting to any person or firm injured or damaged by Provider, its agents, officers, employees, or contractors by Provider's publication, translation, reproduction, delivery, performance, use or disposition of any data processed under this Agreement in a manner not authorized by this Agreement or by federal or state regulations or statutes;
- (d) Any failure of Provider, its agents, officers, employees or contractors to observe the federal or state laws, including, but not limited to, labor laws and minimum wage laws;
- (e) Any claims for damages, losses or reasonable costs associated with legal expenses, including, but not limited to, those incurred by or on behalf of DHH in connection with the defense of claims for such injuries, losses, claims or damages specified above; and
- (f) Any injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against DHH or their agents, officers or employees, through the intentional conduct, negligence or omission of Provider, its agents, officers, employees or contractors.

In the event that, due to circumstances not reasonably within the control of Provider, Company or DHH, (i.e., a major disaster, epidemic, complete or substantial destruction of facilities, war, riot or civil insurrection), neither Provider, Company, DHH or contractor(s), will have any liability or obligation on account of reasonable delay in the provision or the arrangement of covered services; provided, however, that so long as this Agreement remains in full force and effect, Provider shall be liable for the Covered Services required to be provided or arranged for in accordance with this Agreement.

DHH will provide prompt notice of any claim against it that is subject to indemnification by Provider under this Agreement. Provider may, at its sole option, assume the defense of any such claim. DHH may not settle any claim subject to indemnification hereunder without the advance written consent of Provider, which shall not be unreasonably withheld.

6.8 Conflict of Interest. Provider may not contract with Company unless such safeguards at least equal to federal safeguards (41 USC 423) are in place per the state Medicaid director letter dated December 30, 1997 and 1932 (d)(3) of the Social Security Act addressing the 1932 State Plan Amendment and the default enrollment process under the State Plan Amendment option.

6.9 Severability. If any provision or requirement of this Agreement, including items incorporated by reference, is determined by DHH to conflict with the State Contract between DHH and Company, such requirement shall be null and void and all other provisions shall remain in full force and effect. In addition, if the laws or regulations governing the State Contract should be amended or judicially interpreted as to render fulfillment of the State Contract impossible or economically infeasible, such that Company is discharged from its obligations under the State Contract, Provider shall also be discharged from further obligations created under the terms of this Agreement.

6.10 Non Exclusive Clause. Nothing in this Agreement shall be construed to prohibit Provider from entering into a contract or arrangement with any other health plan or managed care entity. Nor shall anything in this Agreement be construed to prohibit Company from entering into a contract or arrangement with any other provider. Company shall not advertise or otherwise hold itself out as having an exclusive relationship with Provider or any service provider.

6.11 Transfer of Agreement. This Agreement may not be transferred by Provider without prior written consent of Company.

7. DELEGATION

7.1 Delegation. Provider shall not enter into any subsequent agreements with subcontractors for any of the work contemplated under this Agreement without Company's prior approval. In the event that duties are delegated hereunder, Company shall:

- (a) Along with Provider, oversee all of subcontractor's performance for delegated activities;
- (b) Ensure, along with Provider (if applicable) that subcontracts fulfill the requirements of 42 C.F.R. Part 438, as appropriate to the delegated activities;
- (c) Have the right to review, approve and/or disapprove or any and all subcontracts entered into for the provision of services hereunder;
- (d) Evaluate, in its discretion, subcontractor's ability to perform the activities to be delegated;
- (e) Require a written agreement with subcontractor, specifying the activities and reporting responsibilities delegated to subcontractor, including revocation of or imposition of sanctions for subcontractor's inadequate performance;
- (f) Identify areas of deficiencies or improvement and take corrective action; and
- (g) Deny payments for provider preventable conditions, per the State Contract.

7.2 Credentialing. If applicable, this Agreement shall set forth a written description of the delegation of credentialing activities delegated to subcontractor. The subcontractor must provide assurance, at all times during this Agreement, that all medical professionals are credentialed in accordance with DHH's credentialing requirements. The Parties and subcontractor understand that DHH shall have final approval over a delegated entity. The Parties agree that subcontractor shall:

- (a) Load provider files into its Claims processing system within thirty (30) calendar days of receipt;

- (b) Notify Company immediately if a provider credentialing application is denied for reasons related to program integrity or otherwise limits the ability of a provider to participate;
- (c) Process re-credentialing not less than once every three (3) years;
- (d) Adopt policies or implement Company's policies and procedures to approve, terminate or suspend providers to ensure compliance with this Agreement and the State Contract; and
- (e) Implement and/or assist with a provider dispute or appeal process.

Subcontractor agrees and understands that, pursuant to the State Contract, DHH and/or the State of Louisiana or its representative, reserved the right to contract with a single Credential Verification Organization ("CVO") under the State Contract. In such event, Provider and/or subcontractor agree that this Agreement shall be terminated concurrent with the minimum notice of ninety (90) days as provided to Company by DHH of such implementation of any CVO contract.

7.3 Audits. Provider and subcontractor agree and understand that subcontractors and delegated entities are subject to the audit requirements and the requirements for the adjudication of Claims under the State Contract.

Exhibit B

Louisiana State Compliance Addendum

This Louisiana State Compliance Addendum is incorporated by reference in this Agreement. This **Exhibit B** shall supplement **Exhibit A** and control, unless such provision conflicts with the State Contract or Louisiana Department of Health and Hospitals' ("DHH") rules and regulations.

For purposes of this **Exhibit B**, the term "Provider" shall mean the health care physician, provider, group, facility or hospital executing this Agreement, as identified on the first page of this Agreement. The term "Covered Services" shall include the Provider Services, Physician Services, Group Services, Hospital Services, Specialty Services and Covered Services referenced in the Agreement.

1.0 DEFINITIONS

Capitalized terms used in this **Exhibit B** that are not defined herein shall have the meaning set forth in **Exhibit A** and/or the main Agreement. When used in this **Exhibit B**, all capitalized terms shall have the following meanings:

1.1 Balance Billing. A prohibited practice in which a Member is billed by a Participating Provider for amounts in excess of the reimbursement paid to the Participating Provider under the terms of the Plan or applicable benefit program. See La. R.S. 22:1880.

1.2 Company Liability. Company's contractual liability, including the financial responsibility, for Covered Services pursuant to the Plan or applicable health benefit program between Member and Company. With respect to Provider, Company Liability is the contracted reimbursement rate reduced by the patient responsibility, which includes Coinsurance, Copayments, Deductibles or any other amounts identified by Company on an explanation of benefits or evidence of coverage as amount for which the Member is liable for the Covered Service. La. R.S. 22:1872(20).

1.3 Clean Claim. A claim, including an accepted claim, that has no defect or impropriety, including any lack of required substantiating documentation, such as satisfactory evidence of expenses incurred or particular circumstances requiring special treatment that prevents timely payment from being made on the claim. La. R.S. 22:1188.1(A); La. R.S. 22:1831(3).

1.4 Electronic Claim. A claim submitted by a Provider or its agent to Company in compliance with the provisions of HIPAA (42 U.S.C. 1302d *et seq.* and 45 C.F.R. Parts 160 and 162) and in a format currently adopted by the United States Department of Health and Human Services or its successor. La. R.S. 22:1831(7).

1.5 Emergency Medical Condition. A medical condition manifesting itself by symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention would result in serious impairment to bodily functions, serious dysfunction of a bodily organ or part, or would place the person's health or, with respect to a pregnant woman, the

health of the woman or her unborn child, in serious jeopardy. La. R.S. 22:1019.1(D)(6); La. R.S. 22:1122(15); La. R.S. 22:1821; La. R.S. 22:2392.

1.6 Emergency Services. The health care items and services furnished or required to evaluate and treat an Emergency Medical Condition. For hospitals, those services that are usually and customarily available at the respective hospital and that must be provided immediately to stabilize a medical condition which, if not stabilized, could reasonably be expected to result in the loss of the person's life, serious permanent disfigurement or loss or impairment of the function of a bodily member or organ, or which is necessary to provide for the care of a woman in active labor if the hospital is so equipped and, if the hospital is not so equipped, to provide necessary treatment to allow the woman to travel to a more appropriate facility without undue risk of serious harm. La. R.S. 22:1019.1(D)(7); La. R.S. 22:1139; La. R.S. 40:2113.6(C).

1.7 Health Care Services. Any services rendered by Providers which include but are not limited to medical and surgical care; psychological, optometric, optic, chiropractic, podiatric, nursing, and pharmaceutical services; health education, rehabilitative, and home health services; physical therapy; inpatient and outpatient hospital services; dietary and nutritional services; laboratory and ambulance services; and any other services for the purpose of preventing, alleviating, curing, or healing human illness, injury, or physical disability. Health care services shall also mean dental care, limited to oral and maxillofacial surgery as performed by board qualified oral and maxillofacial surgeons. The term shall also include an annual Pap test for cervical cancer and minimum mammography examination as defined by state law and coverage for low protein food products as provided in La. R.S. 22:246. The services, items, supplies or drugs for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease. La. R.S. 22:242(6); La. R.S. 22:1019.1(D)(14); La. R.S. 22:1122(24); La. R.S. 22:1831(12); La. R.S. 1872(17).

1.8 Life-Threatening Illness. A severe, serious or acute condition for which death is probable. La. R.S. 22:1005(A)(6).

1.9 Louisiana Department of Health and Hospitals ("DHH"). The state department responsible for promoting and protecting health and ensuring access to medical, preventive and rehabilitative services for all citizens in the State of Louisiana.

1.10 Medical Communication. Information regarding the mental or physical health care needs or the treatment of a Member. La. R.S. 22:1007(C).

1.11 Medically Necessary or Medical Necessity. Those health care services that are in accordance with evidence-based medical standards or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the appropriate treatment or standard of care. In order to be considered medically necessary, services must be: (1) deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain or have resulted or will result in a handicap, physical deformity or malfunction; and (2) for those for which no equally effective, more conservative or less costly course of treatment is available or suitable for the recipient. Unless otherwise mandated by law, any such services must be individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the recipient requires at that specific point in time. *See* La. R.S. 22:1821.

1.12 Non-Electronic Claim. A claim submitted by Provider or its agent to Company or its agent using a HCFA 1500 form or a Uniform Billing Form 92 (UB92), as appropriate, or a successor to either of these forms adopted by the National Uniform Billing Committee or its successor. La. R.S. 22:1831(17).

1.13 Protected Health Information. Health information (i) that identifies an individual who is the subject of the information, or (ii) with respect to which there is a reasonable basis to believe that the information could be used to identify an individual. La. R.S. 22:2392.

1.14 Participating Provider. A state-licensed, certified or state-registered provider of health care services, treatment, or supplies, including but not limited to those entities defined in La. R.S. 40:1299.41(A)(1), that have entered into a contract or agreement with a managed care entity to provide such services, treatment, or supplies to an individual Member or a patient. Participating Provider also includes any Provider who, under contract or agreement with a health insurance issuer, such as Company and as defined in the Louisiana Insurance Code (Title 22), or with its contractor or subcontractor, has agreed to provide Covered Services to Members with an expectation of receiving payment, other than in-network Coinsurance,

Copayments and/or Deductibles, directly or indirectly from Company or the health insurance issuer. La. R.S. 22:1007(A)(5); La. R.S. 22:1019.1(D)(18).

1.15 Provider. Any physician, hospital, practitioner or other person, organization, institution or group of persons licensed, certified, registered or otherwise authorized in the State of Louisiana to furnish health care services. Provider includes any physician licensed by the Louisiana State Board of Medical Examiners (“LSBME”) to practice medicine or other health care practitioner licensed, certified or registered to perform specified health care services consistent with state law subject to direct supervision by such a licensed physician and may, in accordance with state law, include a hospital or other licensed inpatient center, ambulatory surgical or treatment center, skilled nursing facility, inpatient hospice facility, residential treatment center, diagnostic, laboratory or imaging center or rehabilitation or other therapeutic health setting. La. R.S. 22:242(8); La. R.S. 22:1005(A)(4); La. R.S. 22:1831(11). The definition of Provider shall also include the term “Health Care Provider” as set forth in the Medical Malpractice Act, La. R.S. 40:1299.41, as applicable.

2.0 PROVIDER SERVICES AND OBLIGATIONS

2.1 Hours and Availability. Provider agrees and understands that Company must maintain a sufficient network where providers are available to provide or arrange for the provision of Covered Services twenty-four (24) hours per day, seven (7) days per week, three hundred sixty-five (365) days per year, and Provider shall cooperate with Company in adhering to this requirement as applicable and in accordance with state law. La. R.S. 22:1019.2(A).

2.2 Required Disclosures. When applicable, Provider shall comply with the entity ownership disclosure provisions of 42 C.F.R. § 455, Subpart B and disclose all required information regarding significant business transactions, ownership and control information to Company in accordance with the requirements of 42 C.F.R. § 455.104-.106 and as also required by DHH and/or LDI regarding Provider’s ownership interests.

2.3 Provider and General Liability Insurance. Provider shall provide and maintain adequate professional and general liability insurance coverage for any professional medical services rendered, including those rendered outside of the scope of this Agreement, throughout the entire term of this Agreement of not less than One Hundred Thousand Dollars (\$100,000.00) per occurrence and Three Hundred Thousand Dollars (\$300,000.00) in the annual aggregate and participate in the Louisiana Patient Compensation Fund as a qualified health care provider or be self-insured in accordance with and pursuant to, La. R.S. 40:1299.41 *et seq.*

2.4 Notice of Malpractice Actions. Provider shall advise Company of any adverse medical review panel opinion and/or pending professional responsibility lawsuit or action against Provider and the final disposition of any adverse medical review panel opinion or professional liability settlement or judgment entered into by Provider within fifteen (15) days following said filing, settlement or judgment. *See* La. R.S. 40:1299.41 *et seq.*

2.5 Compliance with Ethical Standards. Provider shall at all times during the term of this Agreement, comply with all applicable rules, regulations and instructions, of the Louisiana State Board of Medical Examiners and the ethical standards of the American and Louisiana Medical Associations. *See* La. R.S. 37:1285; applicable federal and state rules and agency regulations.

2.6 Continuing Education. During the entire term of this Agreement, Provider shall maintain his or her professional competence and skills commensurate with the medical standards of the community, and as required by law, by attending and participating in approved continuing education courses.

2.7 Notice of Revocation, Suspension or Restriction of Drug Enforcement Agency Number or Debarment from Federal Program Participation. Provider shall notify Company immediately, in writing, should his or her Drug Enforcement Agency Number be revoked, suspended or restricted, or lapse, or should Provider be barred from participating in federal healthcare programs.

2.8 Non-compliant Members. If Provider desires to discharge a Member, Provider shall provide prior written notice of such desire to discharge the Member to Company. Provider agrees to continue to provide Covered Services to such Member

under the same terms and conditions as set forth in this Agreement until such time as Company makes appropriate arrangements for another Participating Provider to accept such Member as a patient.

2.9 Member Protections. Provider agrees to observe, protect and promote the rights of Members as patients in accordance with state law and all rules and regulations promulgated by the Louisiana Department of Insurance (“LDI”) and DHH, including a Patient’s Bill of Rights, any and all applicable patient protection laws, and other laws promoting the well-being of patients enrolled in a Plan. La. R.S. 22:971.

2.10 Emergency/Catastrophe Response Plan. When applicable, Provider agrees to become familiar with and abide by the terms and procedures set forth in Company’s emergency or catastrophe response, management or operations plan as required and approved by DHH, LDI or other governmental body, including, but not limited to, the execution of a memorandum of understanding with Company if Provider is located in a parish where services may be provided to evacuated Members, if so required by Company. Provider acknowledges and understands that said plan is confidential and the Proprietary Information of Company. This provision shall survive any termination of this Agreement. La. R.S. 22:572.

2.11 Company Access Plan. Provider acknowledges and understands that Company is required to annually submit a network access plan or other proof of accreditation for filing with LDI. Provider agrees to cooperate with Company to timely provide all necessary information so that Company can meet its obligations under state law regarding network adequacy reporting and planning. La. R.S. 22:1019.2.

3.0 COMPANY OBLIGATIONS

3.1 No Interference By Company. Company agrees that it will not prohibit or otherwise restrict Provider, acting within the lawful scope of practice, from advising or advocating on behalf of a Member who is his or her patient:

- (a) For the Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;
- (b) For any information the Member needs in order to decide among all relevant treatment options;
- (c) For the risks, benefits, and consequences of treatment or non-treatment; and
- (d) For 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.

Company agrees that it will not prohibit or restrict Provider from filing a complaint, making a report or commenting to an appropriate governmental body regarding the policies or practices of Company which may negatively impact upon the quality of, or access to patient care in accordance with state and federal law. La. R.S. 22:1007; 42 C.F.R. § 438.102(a)(1)(i)-(iv).

3.2 Confidentiality of Member Medical Information. Company agrees that any data or information pertaining to the diagnosis, treatment or health of a Member or potential Member obtained from Provider shall be held in confidence and shall not be disclosed except:

- (a) To the extent that it may be necessary to comply with the Louisiana Health Maintenance Organization Act (La. R.S. 22:240 *et seq.*) or as otherwise permitted by law;
- (b) Upon the express consent of the Member or potential Member;
- (c) Pursuant to state law or court order for the production of evidence or the discovery thereof; and
- (d) In the event of a claim or litigation between any such person and Company, wherein such data or information is pertinent.

La. R.S. 22:265(A).

3.3 Open Communication With Members. Nothing in this Agreement shall be construed to in any way impede the open clinical dialogue and clinical communication between Provider and Members or otherwise interfere with Provider's ability to communicate with a Member regarding his or her health care, including but not limited to communications regarding treatment options, medical alternatives or other coverage arrangements. Company shall encourage Physician to freely communicate with Members about clinical treatment options, including medications, available to them, regardless of benefit coverage limitations. Notwithstanding the provisions of this Section, Provider shall not solicit for alternative coverage arrangements for the primary purpose of securing financial gain. La. R.S. 22:1007(B).

3.4 Required Disclosures by Company. To ensure that Company does not have any "silent PPO" arrangements, Company shall disclose within forty-five (45) days following the written request of Provider:

- (a) The list of clients or other payors entitled to a contracted rate under Company's contract with Provider; and
- (b) The specific clients or other payors by whom a contracted rate was applied to a particular claim under Company's contract with Provider.

La. R.S. 40:2203.1.

3.5 Communication of Plan and Health Benefit Program Changes. In order to prevent or reduce the risk of misinformation, Provider agrees that Company shall have the exclusive right and responsibility to communicate changes in the Plan or other health benefit programs to Members. It is understood, however, that this shall not be interpreted as restricting in any way Provider's ability to freely communicate medical advice to Members, and shall not be construed as prohibiting any communication subject to the protections of La. R.S. 22:1007.

3.6 Hearing Impaired Interpreter Expenses. In the event a Member requires the services of a qualified interpreter or translator for use in connection with medical treatment or diagnostic consultations performed by Provider, such services shall be covered by Company and provided at no expense to Provider. La. R.S. 22:245; La. R.S. 22:1027.

4.0 CLAIMS SUBMISSION, COMPENSATION AND MEMBER BILLING

4.1 Compensation; Reimbursement Rates. The payments rendered or to be rendered to Providers under this Agreement, as may be amended from time to time, shall be deemed and shall remain confidential information. This provision shall survive any termination of this Agreement. La. R.S. 22:263(F).

4.2 Balance Billing. Notwithstanding any provisions of the Agreement and Exhibit D, if Company obtains knowledge that Provider has engaged in "Balance Billing" in violation of this Agreement and applicable law, Company may direct Provider to immediately refund such amounts to Members. Any such fine may be offset against payments due to Provider by Company. Company may also report said violations of law to CMS and/or LDI. See La. R.S. 22:1880.

4.3 Electronic Claims. Any Electronic Claim submitted by Provider shall be paid, denied or pended by Company within twenty-five (25) days from the date the Electronic Clean Claim is received by Company, unless (i) the claim is not payable under the terms of the Plan or (ii) just and reasonable grounds exist. Within five (5) working days of receipt of an Electronic Claim, Company shall review the entire claim and, if Company determines that the claim is not an accepted claim or Clean Claim, Company shall issue an exception report to Provider indicating all defects or reasons known at that time that the claim is not an accepted claim. If Provider submits a claim that is not an accepted claim, the claim shall be deemed to have been timely submitted for payment of Covered Services if Company fails to notify Provider, or the health care clearinghouse from which the claim was received, of all defects or reasons known at that time that the claim is not an accepted claim as required by state law. Company shall establish appropriate procedures, as approved by LDI, to assure that Provider receives a late payment adjustment equal to the amounts required by law if Provider is not paid within the statutory time frames. La. R.S. 22:1833.

4.4 Non-Electronic Claims. Any Non-Electronic Claim submitted by Provider within forty-five (45) days of the date of service or date of discharge from a health care facility, shall be paid, denied or pended by Company within forty-five (45) days from the date the Non-Electronic Clean Claim is received by Company, unless (i) the claim is not payable under the terms of the Plan or (ii) just and reasonable grounds exist. Any Non-Electronic Claim submitted by Provider more than forty-five (45) days after the date of service or date of discharge from a health care facility or resubmitted because the original claim was not an accepted claim or Clean Claim, shall be paid, denied or pended by Company within sixty (60) days from the date the Non-Electronic Clean Claim is received by Company, unless (i) the claim is not payable under the terms of the Plan or (ii) just and reasonable grounds exist. Company shall have appropriate handling procedures in place, as approved by LDI, for the processing of Non-Electronic Claims and any adjustments required for late payments to Providers. Provider shall be entitled to a late payment adjustment of twelve percent (12%) for any Non-Electronic Claim not paid within the time frames specified in this Section. La. R.S. 22:1832.

4.5 Payment of Claims. Upon written notice to and approval from LDI, Company may elect to utilize a thirty (30) day payment standard for compliance with the requirements of paying Electronic Claims and Non-Electronic Claims. Should Company elect this standard, it shall continue to meet all other requirements of state law and Regulation 74 as issued by LDI. See La. Admin. Code, Title 37, Part XIII § 6011.

However, when applicable, EPSDT screening claims must be submitted within sixty (60) days from date of service to accommodate for the frequency of screening services and for EPSDT reporting requirements. EPSDT screening claims must also include information related to immunizations, referrals and health status as published in the EPSDT Services Rule (*Louisiana Register*, Vol. 30, No. 8). Notwithstanding the foregoing, Provider must submit all claims for Covered Services for payment no later than twelve (12) months from the date of service. Provider shall retain any and all supporting financial information and documents that are adequate to ensure that payment is made in accordance with applicable federal and state laws and the provisions of this Agreement. La. R.S. 22:1821.

Company shall pay Provider the contracted reimbursement rate of the network identified on the member identification card of the Member, pursuant to La. R.S. 40:2203.1, and as established by this Agreement. To the extent Company does not pay Provider an amount equal to the Company Liability, the Provider may collect the difference between the amount paid by Company and the Company Liability from the Member. Any such collection efforts shall not constitute a violation of state law. La. R.S. 22:1874(4).

If Provider is a rural hospital, Company shall not limit the right of the rural hospital to receive payment for Covered Services when a claim for such services is submitted within one (1) year after the date on which the rural hospital provided the services. La. R.S. 22:1007(A)(6), (H); La. R.S. 22:1831(21).

4.6 Late Payment of Clean Claims. If Company fails to comply with the timely payment provisions for Clean Claims, Company shall pay Provider interest at the rate of one percent (1%) per month on the amount of the claim that should have been paid but that remains unpaid forty-five (45) business days after the receipt of the claim pursuant to or after receipt of all requested additional information pursuant to the requirements of state law. The interest payable shall be included in any late reimbursement without requiring the Provider or his or her designee who filed the original claim to make any additional claim for such interest. However, the provisions of this Section shall not apply where Company has a reasonable basis supported by specific evidence that such claim was fraudulently submitted. La. R.S. 22:1188.1.

4.7 Recoupment; Offsets; Adjustments. With respect to Members who are not Medicare Beneficiaries, Company shall not retroactively deny payment or recoup any monies paid for Covered Services beyond ninety (90) days from the expiration of the allowable thirty (30) day period for the payment of any claim when the denial or recoupment is based on a determination that the Member was no longer covered under a Plan at the time the Covered Services were provided.

Prior to any recoupment, offset or adjustment that is unrelated to a claim for services provided by Provider or any other amount owed by Company to Provider, Company shall provide Provider written notification that includes the name of the Member, date(s) of services rendered and explanation of the reason for recoupment. Provider may appeal Company's action in writing within by thirty (30) days from receipt of written notification of the recoupment. If Provider fails to respond timely, in writing, to Company's written notification of recoupment, the recoupment is deemed accepted. If accepted, Provider may remit the agreed amount to Company at the time of written notification of acceptance or Company may deduct

the agreed amount from future payments due to Provider. If Provider disputes Company's written notification of recoupment, any dispute shall be resolved according to the dispute resolution provisions of this Agreement. La. R.S. 22:1838.

4.8 Hold Harmless; Exception. In addition to the requirements of Section 4.3 of the main Agreement, Physician may not maintain any action at law against a Member for a Company Liability or for payment of any amount in excess of the contracted reimbursement rate for Covered Services. In the event of such an action, the prevailing Party shall be entitled to recover all costs incurred, including reasonable attorney fees and court costs. Notwithstanding the forgoing, Physician is not prohibited from maintaining any action at law against a Member after Company determines that Company is not liable for the services rendered. La. R.S. 22:1874.

4.9 Prohibited Inducements. Nothing in this Agreement shall be construed to provide an incentive or specific payment from Company, directly, indirectly or in any form, to Provider as an inducement to deny, reduce, limit or delay Medically Necessary and appropriate services provided with respect to a specific Member or group of Members with similar medical conditions. La. R.S. 22:263(E); La. R.S. 22:1008.

5.0 COMPLIANCE WITH POLICIES

5.1 Compliance with State and Federal Laws and Regulations. Provider and Company shall comply with all applicable state and federal laws, rules and regulations, including state agency materials issued by LDI, DHH or other regulatory authority, when applicable.

5.2 Confidentiality and Accuracy of Member Records. Provider shall, with respect to any medical records or other health and enrollment information which Provider maintains with respect to Members:

- (a) Safeguard the privacy of any information that identifies a particular Member. Information from, or copies of, records may be released only to authorized persons. Unauthorized persons shall not be permitted to gain access to or alter patient records. Original medical records shall be released by Provider only in accordance with federal and state laws, court orders and subpoenas;
- (b) Maintain such records and information in an accurate and timely manner;
- (c) Ensure timely access by Members to the records and information that pertain to them; and
- (d) Abide by all federal and state laws regarding confidentiality and disclosure of mental health records, medical records, other health information, and other information with respect to Members.

La. R.S. 22:265.

5.3 Ownership of Records. All Member medical records maintained at Provider's office are deemed to be the property and business records of Provider. La. R.S. 40:1299.96(A).

5.4 Access to Information and Records. With respect to Section 5.3 of the main Agreement, said provision shall apply equally and with full force and effect to LDI and DHH.

5.5 Disclosure of Protected Health Information. With respect to an external review of Member grievances and appeals, Company shall obtain an authorization from Members, in a form that meets the requirements of 45 C.F.R. § 164.508 and is approved by LDI, that authorizes Company and Provider to disclose Protected Health Information, including medical records, concerning the Member that are pertinent to the external review. La. R.S. 22:2433.

5.6 Data Reporting. Provider shall provide all necessary information to enable Company to meet its reporting requirements under state and federal law, including encounter data reporting. Provider shall submit data in a form acceptable to applicable state agencies.

5.7 Compliance with Company Prescription Drug Lists. Provider shall comply, unless medical necessity dictates otherwise, with prescription drug lists developed and/or adopted by Company, the State Contract and contracting Plans.

6.0 TERM AND TERMINATION

6.1 Prohibited Changes to Term. Company shall not refuse to contract, renew, cancel, restrict or otherwise terminate this Agreement with Provider solely on basis of a Medical Communication. Additionally, Company shall not refuse to refer Members to Provider, refuse to compensate Provider for Covered Services or take other retaliatory action against Provider on the basis of a Medical Communication. La. R.S. 22:1007(C).

6.2 Continuity of Care. In the event this Agreement is terminated, Provider shall notify Company of any Member who has begun a course of treatment by Provider before the effective date of the termination. Upon such notice, Company shall notify the Member of the termination of Provider from Company's network and the Member's right to continuity of care. Upon termination of this Agreement, the following provisions shall apply:

- (a) In the event Member has been diagnosed as being in a high-risk pregnancy or is past the twenty-fourth (24th) week of pregnancy, Member shall be allowed to continue receiving Covered Services, subject to the consent of Provider, through delivery and postpartum care related to the pregnancy and delivery.
- (b) In the event a Member has been diagnosed with a Life-Threatening Illness, Member shall be allowed to continue receiving Covered Services, subject to the consent of Provider, until the course of treatment is completed, not to exceed three (3) months from the effective date of such termination.
- (c) In the event Provider advises Company of a Member who meets the criteria of the foregoing paragraphs, Company shall continue payment of the Company Liability to Provider that was in effect prior to the termination of this Agreement. In addition, the contractual requirements for Provider to follow Company's utilization management and quality management policies and procedures, when applicable, shall remain in effect for the applicable period described above.
- (d) Provider shall be prohibited from discount billing and dual billing as prohibited by the Louisiana Health Care Consumer Billing and Disclosure Protection Act (La. R.S. 22:1871 *et seq.*); however, Provider shall be deemed to be a contracted Provider with Company for payment purposes for services provided pursuant to this Section.

La. R.S. 22:1005(B).

6.3 Continuity of Care; Exceptions. Notwithstanding the foregoing, the continuity of care provisions above shall not apply when:

- (a) The reason for such termination is due to suspension, revocation, or applicable restriction of the Provider's license to practice in this state by the Louisiana State Board of Medical Examiners or for another documented reason related to quality of care;
- (b) The Member chooses to change Providers;
- (c) The Member moves out of the geographic service area of the health care provider or health insurance issuer; and
- (d) The Member requires only routine monitoring for a chronic condition but is not in an acute phase of the condition.

La. R.S. 22:1005(C).

7.0 RELATIONSHIP OF THE PARTIES

7.1 Independent Contractor. At all times relevant and pursuant to the terms and conditions of this Agreement, Provider is and shall be construed to be an independent contractor, as interpreted and construed under Louisiana law, practicing Provider's profession and shall not be deemed to be or construed to be an agent, servant or employee of Company.

7.2 Cooperation with Other Contractors. In the event that Company has entered into, or enters into, agreements with other subcontractors for additional work related to the services rendered hereunder, including, but not limited to fiscal intermediary and enrollment broker services, Provider agrees to cooperate fully with such other contractors. Provider shall not commit any act that will interfere with the performance of work by any other contractor. Provider's failure to cooperate and comply with this provision, shall be sufficient grounds for Company to halt all payments due or owing to Provider until it becomes compliant with this or any other contract provision. Company's determination on the matter shall be conclusive and not subject to appeal.

8.0 DISPUTE RESOLUTION

8.1 Grievance Procedure. A grievance procedure has been established for the processing of any Member complaints regarding Covered Services furnished by Provider. Provider shall comply with and, subject to Provider's rights of appeal, shall be bound by such grievance procedure. A copy of the grievance procedure, which is subject to amendment, shall be made available to Provider in hard copy or by electronic access by Company. In addition, Provider shall adhere to all appeal/expedited appeal procedures for Medicare and/or Medicaid beneficiaries, including the gathering and forwarding of information on appeals to the Company, as necessary. La. R.S. 22:263(A)(3).

8.2 Assistance with Member Grievance Dispute Resolution. When required by Company or applicable law, Provider shall display notices of a Member's right to any appeal adverse action affecting Covered Services in public areas of Provider's facility(ies). Upon request from Provider, Company shall furnish Provider with additional copies of public notices and appeal forms. At Provider's discretion, Provider may file a grievance on behalf of a Member; however, Provider shall adhere to the requirements and grievance and appeals procedures outlined by Company, CMS, DHH or other governmental body. Notwithstanding any Company, CMS or DHH grievance and appeal process, rule or contractual provision to the contrary, Provider is not precluded from pursuing relief through a court of appropriate jurisdiction for the resolution of a provider initiated grievance or appeal.

Provider shall follow appropriate procedures, developed by Company, regarding emergency appeals and when an emergency appeal is appropriate. Provider shall comply with all appeal processes and shall assist Members by providing appeal forms and contact information, including the appropriate address, telephone number and/or fax number for submitting appeals for Company and/or state level review. La. R.S. 22:267.

8.3 Member Appeals and Grievance Procedures. Provider shall abide by the determination of the Company Member grievance procedure, including but not limited to, grievance procedures for resolving disputes regarding the necessity for continued treatment. Company and Provider agree and understand that they will not engage in any retaliatory action against a Member because the Member has filed a complaint against or appealed a decision of Company. Company will not engage in any retaliatory action, including termination or refusal to renew a contract, against Provider, because Provider has, on behalf of a Member, filed a complaint against, or appealed a decision of Company. In the event the Member submits an appeal to Company, Provider shall fully cooperate with and abide by Company's appeals and grievances procedures, including any and all internal claims and appeals processes and external reviews required by law. Company shall provide Provider with the documentation of the Member's appeal. Provider shall review the documentation of the Member's appeal, performing any necessary research or investigation and providing a determination and response to Company within (3) days of receipt from Company of a Member appeal, or in the time frame required by LDI or as otherwise designated by Company. La. R.S. 22: 2391 *et seq.*

When applicable, Provider agrees to comply with Company's procedures for Medicare Advantage Member grievances, organization determinations and Medicare Advantage Member appeals as required by the Medicare Advantage Program.

Without limiting the generality of the foregoing, in the event the Member is a Medicare Advantage Member and submits an appeal to Company, Company shall, upon request of Provider, furnish Provider with copies of the Medicare Advantage Member's appeal. Provider shall, if so requested by Company, review the Medicare Advantage Member's appeal, performing any necessary research or investigation and providing a determination and response to Company within twenty-four (24) hours of receipt from Company of the complete appeal file for a Medicare Advantage Member, unless such longer time is permitted by current CMS guidelines. La. R.S. 22:267.

9.0 MISCELLANEOUS

9.1 Governing Law. This Agreement shall be exclusively governed by, construed and enforced in accordance with Louisiana laws, except to the extent such laws conflict with or are preempted by any federal law, in which case such federal law shall govern.

9.2 Incorporation of Changes to Laws and Regulations. This Agreement incorporates by reference all applicable federal and state laws or regulations, and revisions of such laws or regulations shall automatically be incorporated into this Agreement as they become effective. In the event that there changes to this Agreement as a result of revisions to applicable federal or state law, and such revisions materially affect the position of either Party. Company and Provider agree to negotiate such further amendments as may be necessary to correct any inequities.

Exhibit D

Medicare Compliance Addendum

Provider shall comply, and shall cause its Downstream Entities to comply, with the requirements set forth in this Exhibit D, *Medicare Requirements* with respect to the provision of Services under the Agreement, including the performance of delegated activities in connection with Company or its subsidiaries or Affiliates' Medicare Advantage and/or Part D Program (including D-SNP or MMP). Except as provided herein, all other provisions of the Agreement between Company and Provider not inconsistent herein shall remain in full force and effect. This Exhibit D shall supersede and replace any inconsistent provisions to the Agreement; to ensure compliance with required CMS provisions, and shall continue concurrently with the term of the Agreement. Provider's obligations specifically include the following:

A. Medicare Required Provisions.

Provider agrees to comply with all of the provisions of Exhibit D, Schedule 1, attached hereto and incorporated into the Agreement.

B. Other Medicare Requirements – Provider Obligations.

1. Maintenance of Records and Audits

- (a) Company or its designee(s) shall have the right, but not the obligation, to audit, inspect and copy, during regular business hours at Company's cost and in a manner that does not unreasonably interfere with Provider's business, any books and records Provider maintains pursuant to the Agreement and the Services performed, upon ten (10) business days' written notice to Provider; but only to the extent that such inspection is not prohibited by applicable law. To the extent that Company uses a third-party to audit Provider, such third party may not be a competitor of Provider and shall execute a confidentiality agreement acceptable to Provider, such acceptance shall not be unreasonably denied, delayed or withheld.
- (b) Provider shall maintain (and shall cause Downstream Entities to maintain) operational, financial, administrative and medical records, contracts, books, files and other documents as required legally or as are reasonable in the industry in connection with Services performed under the Agreement ("Records"). Such Records shall be

maintained in a timely and accurate manner and shall, at a minimum, be reasonably sufficient to allow Company to determine whether Provider and its Downstream Entities are performing their obligations under the Agreement consistent with the terms of the Agreement and in accordance with applicable law and to confirm that the data submitted by Provider and its Downstream Entities for reporting and other purposes is accurate.

- (c) The terms of this paragraph 4, including with respect to maintenance of Records by Provider and Downstream Entities, shall remain in effect for a period of ten (10) years following the termination of the agreement between CMS and Company.
2. **Compliance With Law.** Provider acknowledges that Company, directly or indirectly, receives federal funds and that as a contractor of Company, the payments to Provider under the Agreement are, in whole or in part, from federal funds. In carrying out its duties and obligations under the Agreement, Provider shall follow and adhere to all applicable laws, including, but not limited to Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. §2000d et. Seq.); sections 503 and 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§793 and 794); Title IX of the Education Amendments of 1972, as amended (20 U.S.C. § 1681 et. Seq.); section 654 of the Omnibus Budget Reconciliation Act of 1981, as amended (41 U.S.C. §9849); the Americans with Disabilities Act (42 U.S.C. §12101 et. Seq.); and the Age Discrimination Act of 1975, as amended (42 U.S.C. §6101 et. Seq.); the Vietnam Era Veterans Readjustment Assistance Act (38 U.S.C. § 4212); and applicable sections of the Medicare and Modernization Act of 2003, HIPAA and the HITECH Act of 2009, together with all applicable implementing regulations, rules guidelines and standards as from time to time are promulgated thereunder.
 3. **Exclusion Screening and Related Requirements.** Provider shall not employ or contract with, and shall ensure that its Downstream Entities do not employ or contract with, individuals or entities that are excluded under the HHS Office of Inspector General's List of Excluded Individuals/Entities ("OIG List") or otherwise excluded from participation in Medicare or other Federal health care programs, or are debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency ("Excluded Individuals"). Provider shall, and shall cause its Downstream Entities to: (a) review the OIG List and the U.S. General Services Administration's Excluded Parties List System prior to the initial hiring of any employee or the engagement of any Downstream Entity to furnish services to Company's Medicare Program, and monthly thereafter, to ensure compliance with this paragraph; (b) provide documentation, upon written request by Company, of such Exclusion Screening and related requirements; (c) promptly notify Company upon discovering that it, or any of its employees or Downstream Entities, has furnished Medicare program related services to Company under the Agreement as or through an Excluded Individual or that a person or entity furnishing Services under the Agreement has been convicted of a criminal felony that could serve as the basis of Federal health care program exclusion; and (d) promptly remove an Excluded Individual from any work related, directly or indirectly, to Services furnished under the Agreement and use commercially reasonable efforts to take other appropriate corrective action reasonably requested by Company based on the above notification.
 4. **Benefit Continuation.** If applicable to the Services, and to the extent required by applicable law, Provider agrees, and will require its Downstream Entities to agree, to provide for the continuation of Company's Members' health care benefits, for all such Members, for the duration of the contract period for which CMS payments have been made, and for such Members who are hospitalized on the date Company's contract with CMS terminates, or in the event of an insolvency of Company, through the date of the Member's discharge.
 5. **Reporting and Disclosure; Submission of Encounter and Other Data.** Upon request by Company, Provider shall certify, and cause its Downstream Entities to certify, that any data and other information submitted to Company are accurate, complete and truthful based on best knowledge, information and belief. Provider shall provide reasonable cooperation and assistance with Company's requests for information and shall promptly submit encounter data, medical records and such other information as requested by Company to allow Company to respond in a timely manner to any data validation audits or requests for information by CMS, and to monitor and audit the obligation of Provider and Downstream Entities to provide accurate, complete and truthful data and other information. This paragraph 5 shall survive termination of the Agreement, regardless of the cause giving rise to termination.

6. **Offshore Services.** For purposes of this Exhibit, the term “offshore” shall mean any country or territory that is not the United States or one of the United States territories (i.e., American Samoa, Guam, Northern Marianas, Puerto Rico and the Virgin Islands). Provider represents and warrants that it does not and will not use offshore subcontractors, or permit any Members’ protected health information or other personal information to be accessible to any offshore employees, without prior written notice to Company and Company’s prior written approval of such offshore subcontractors and/or offshore use of Member’s PHI or personal information. Prior to Company’s written approval, Company may review and approve Provider’s or its subcontractor’s policies and procedures applicable to such offshore use. In addition to the above, any offshore services shall be subject to all of the standards, terms and conditions set forth in this Amendment and the Agreement the same as if the services were provided within the U.S. This includes, but is not limited to, timely access to records created and/or related to such offshore services, such as customer service call records.
7. **Compliance Program and Anti-Fraud Initiatives.** Provider shall (and shall cause its Downstream Entities 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 relating to the operation of Company’s Medicare Program. Such compliance program shall be appropriate to Provider or Downstream Entity’s organization and operations and shall include: (a) written policies, procedures and standards of conduct articulating the entity’s commitment to comply with Federal and State laws; and (b) for all officers, directors, employees, contractors and agents of Provider or Downstream Entity, required participation in effective compliance and anti-fraud training and education that is consistent with guidance that CMS has or may issue with respect to compliance and anti-fraud and abuse initiatives, unless exempt from such training under relevant CMS regulations.
8. **Marketing Non-Health Related Items.** Provider shall not: (1) engage in any marketing or sales activities that could mislead or confuse Medicare beneficiaries, 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.
9. **Definitions:**
 - (a) **“Affiliate”** means with respect to any person or entity, each of the persons and/or entities that directly or indirectly, through one or more intermediaries, owns or controls, is controlled by or is under common control with, such person or entity. For the purpose of the Agreement, “control” means the possession, directly or indirectly, of the power to direct or cause the direction of management and policies, whether through the ownership of voting securities, by contract or otherwise.
 - (b) **“Centers for Medicare and Medicaid Services (“CMS”)** shall have the meaning set forth in Exhibit D, Schedule 1 of this Exhibit D.
 - (c) **“Downstream Entity”** shall have the meaning set forth in Exhibit D, Schedule 1 of this Exhibit D.
 - (d) **“Medicare Advantage (“MA”)** shall have the meaning set forth in Exhibit D, Schedule 1 of this Exhibit D.
 - (e) **“Medicare Advantage Organization (“MA organization”)** shall have the meaning set forth in Exhibit D, Schedule 1 of this Exhibit D.
 - (f) **“Member or Enrollee”** shall have the meaning set forth in Exhibit D, Schedule 1 of this Exhibit D.
 - (g) **“Part D”** shall have the meaning set forth in Exhibit D, Schedule 1 of this Exhibit D.
 - (h) **“Part D Organization”** shall have the meaning set forth in Exhibit D, Schedule 1 of this Exhibit D.

Exhibit D, Schedule 1
Medicare Advantage Contract Amendment

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 and Provider not inconsistent herein shall remain in full force and effect. This Amendment shall supersede and replace any inconsistent provisions to the Agreement; to ensure compliance with required CMS provisions, and shall continue concurrently with the term of the 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 laws or regulations of the State.
- 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:

Provider agrees to the following:

- 1) HHS, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any pertinent information for any particular contract period, including, but not limited to, any books, contracts, computer or other electronic systems (including medical records and documentation of the First Tier Entity, Downstream

Entity, and other entities related to CMS' contract with Company's Affiliates included in the Agreement) through 10 years from the final date of the final contract period of the contract entered into between CMS and the MA organization or from the date of completion of any audit, whichever is later. [42 C.F.R. §§ 422.504(i)(2)(i) and (ii)]

- 2) Provider will comply with the confidentiality and enrollee record accuracy requirements, including: (1) abiding by all Federal and State laws regarding confidentiality and disclosure of medical records, or other health and enrollment information, (2) ensuring that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas, (3) maintaining the records and information in an accurate and timely manner, and (4) ensuring timely access by enrollees to the records and information that pertain to them. [42 C.F.R. §§ 422.504(a)(13) and 422.118]
- 3) Enrollees will not be held liable for payment of any fees that are the legal obligation of the MA organization. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)]
- 4) Any services or other activity performed in accordance with a contract or written agreement by Provider are consistent and comply with the MA organization's contractual obligations. [42 C.F.R. § 422.504(i)(3)(iii)]
- 5) Provider and any related entity, contractor or subcontractor will comply with all applicable Medicare laws, regulations, and CMS instructions. [42 C.F.R. §§ 422.504(i)(4)(v)]
- 6) If any of the MA organization's activities or responsibilities under its contract with CMS are delegated to any First Tier Entity, Downstream Entity or related entity:

[INFORMATIONAL NOTE: If there is no delegation of a specific activity or responsibility, please delete the related provision.]

- (i) The delegated activities and reporting responsibilities are specified as follows:

[List activities and reporting responsibilities or enter the section and name of the delegation or applicable agreement].

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

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

[Enter any applicable section and name of the delegation or applicable agreement].

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

[Enter any applicable section and name of the delegation or applicable agreement].

- (v) If the MA organization delegates the selection of providers, contractors, or subcontractor, the MA organization retains the right to approve, suspend, or terminate any such arrangement.

[42 C.F.R. §§ 422.504(i)(4) and (5)]

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