Name According to W-9 Form with d/b/a: _____

[redacted] PROVIDER AGREEMENT

This Provider Agreement (hereinafter "Agreement") is made and entered into by and between [redacted] Tennessee, Inc., [redacted] Texas, Inc. (collectively referred in this Agreement as "[redacted] and the undersigned Provider (hereinafter "Provider"), effective as of the date set forth immediately above [redacted] signature (the "Effective Date"). In accordance with this Agreement, [redacted] Tennessee, Inc. manages the Medicaid Program under [redacted] and [redacted] Texas, Inc. manages the Medicare Advantage Program. In consideration of the mutual promises and covenants herein contained, the sufficiency of which is acknowledged by the parties, the parties agree as follows:

[*Alternate preamble for multiple TIN agreement, for use with Participating Provider Exhibit*]
This Provider Agreement (hereinafter "Agreement") is made and entered into by and between [redacted] Tennessee, Inc., [redacted] Texas, Inc. (collectively referred in this Agreement as "[redacted] and _____, ("Provider") on behalf of itself and the Participating Providers set forth on the Participating Providers Exhibit and shall be effective as of the date set forth immediately above [redacted] signature (the "Effective Date"). Unless otherwise specifically delineated, all references herein to "Provider" may also mean and refer to "Participating Provider" as defined below. In accordance with this Agreement, [redacted] Tennessee, Inc. manages the Medicaid Program under [redacted] and [redacted] Texas, Inc. manages the Medicare Advantage Program. In consideration of the mutual promises and covenants herein contained, the sufficiency of which is acknowledged by the parties, the parties agree as follows:

ARTICLE I
DEFINITIONS

"Affiliate" means any person, firm, corporation (including, without limitation, service corporation and professional corporation), partnership (including, without limitation, general partnership, limited partnership and limited liability partnership), limited liability company, joint venture, business trust, association or other entity or organization that (i) now or in the future directly or indirectly controls, is controlled by, or is under common control with the [redacted] and/or (ii) that is identified as an Affiliate on a designated web site as referenced in the provider manual(s). Unless otherwise set forth in the Agreement, an Affiliate may access the rates, terms and conditions of this Agreement.

"Agency" means a federal, state or local agency, administration, board or other governing body with jurisdiction over the governance or administration of a Health Benefit Plan.

"Audit" means a post-payment review of the Claim(s) and supporting clinical information reviewed by [redacted] to ensure payment accuracy. The review ensures Claim(s) comply with all pertinent aspects of submission and payment including, but not limited to, contractual terms, Regulatory Requirements, Coded Service Identifiers (as defined in the WCS) guidelines and instructions, [redacted] medical policies and clinical utilization management guidelines, reimbursement policies, and generally accepted medical practices. Audit does not include medical record review for quality and risk adjustment initiatives, or activities conducted by [redacted] Special Investigation Unit ("SIU").

"Claim" means either the uniform bill claim form or electronic claim form in the format prescribed by [redacted] submitted by a provider for payment by a [redacted] for Health Services rendered to a Member.

"CMS" means the Centers for Medicare & Medicaid Services, an administrative agency within the United States Department of Health & Human Services ("HHS").

"Cost Share" means, with respect to Covered Services, an amount which a Member is required to pay under the terms of the applicable Health Benefit Plan. Such payment may be referred to as an allowance, coinsurance, copayment, deductible, penalty or other Member payment responsibility, and may be a fixed amount or a percentage of applicable payment for Covered Services rendered to the Member.

"Covered Services" means Medically Necessary Health Services, as determined by [redacted] and described in the applicable Health Benefit Plan, for which a Member is eligible for coverage.

"Government Contract" means the contract between [redacted] and an applicable party, such as an Agency, which governs the delivery of Health Services by [redacted] to Member(s) pursuant to a Government Program.

"Government Program" means any federal or state funded program under the Social Security Act, and any other federal, state, county or other municipally funded program or product in which [redacted] maintains a contract to furnish services. For purposes of this Agreement, Government Program does not include the Federal Employees Health Benefits Program ("FEHBP"), or any state or local government employer program.

"Health Benefit Plan" means the document(s) that set forth Covered Services, rules, exclusions, terms and conditions of coverage. Such document(s) may include but are not limited to a Member handbook, a health certificate of coverage, or evidence of coverage.

"Health Service" means those services, supplies or items that a health care provider is licensed, equipped and staffed to provide and which he/she/it customarily provides to or arranges for individuals.

"Medically Necessary" or "Medical Necessity" means the definition as set forth in the applicable Participation Attachment(s).

"Member" means any individual who is eligible, as determined by [redacted] as applicable, and [redacted] to receive Covered Services under a Health Benefit Plan. For all purposes related to this Agreement, including all schedules, attachments, exhibits, provider manual(s), notices and communications related to this Agreement, the term "Member" may be used interchangeably with the terms Insured, Covered Person, Covered Individual, Enrollee, Subscriber, Dependent Spouse/Domestic Partner, Child, Beneficiary or Contract Holder, and the meaning of each is synonymous with any such other.

"Network" means a group of providers that support, through a direct or indirect contractual relationship, one or more product(s) and/or program(s) in which Members are enrolled.

"Participating Provider" means a An institution, facility, agency, physician, health care practitioner, or other entity that is licensed or otherwise authorized to provide any of the Covered Services in the state in which they are furnished and that is party to an agreement to provide Covered Services to Members that has met all applicable required [redacted] credentialing requirements and accreditation requirements for the services the Participating Provider provides, and that is designated by [redacted] to participate in one or more Network(s). Unless otherwise specifically delineated, all references herein to "Provider" may also mean and refer to "Participating Provider". Participating Provider does not include consumer-directed workers (refer to Consumer-Directed Worker); nor does provider include the FEA (refer to Fiscal Employer Agent).

"Participation Attachment(s)" means the document(s) attached hereto and incorporated herein by reference, and which identifies the additional duties and/or obligations related to Network(s), Government Program(s), Health Benefit Plan(s), and/or [redacted] programs such as quality and/or incentive programs.

"Regulatory Requirements" means any requirements, as amended from time to time, imposed by applicable federal, state or local laws, rules, regulations, guidelines, instructions, Government Contract, or otherwise imposed by an Agency or government regulator in connection with the procurement, development or operation of a Health Benefit Plan, or the performance required by either party under this Agreement. The omission from this Agreement of an express reference to a Regulatory Requirement applicable to either party in connection with their duties and responsibilities shall in no way limit such party's obligation to comply with such Regulatory Requirement.

"[redacted] Compensation Schedule" ("WCS") means the document(s) attached hereto and incorporated herein by reference, and which sets forth the [redacted] Rate(s) and compensation related terms for the Network(s) in which Provider participates. The WCS may include additional Provider obligations and specific [redacted] compensation related terms and requirements.

"[redacted] Rate" means the lesser of one hundred percent (100%) of Eligible Charges for Covered Services, or the total reimbursement amount that Provider and [redacted] have agreed upon as set forth in the [redacted] Compensation Schedule ("WCS"). The [redacted] Rate includes applicable Cost Shares, and shall represent payment in full to Provider for Covered Services.

ARTICLE II
SERVICES/OBLIGATIONS

2.1 Member Identification. [redacted] shall ensure that [redacted] provides a means of identifying Member either by issuing a paper, plastic, electronic, or other identification document to Member or by a telephonic, paper or electronic communication to Provider. This identification need not include all information necessary to determine Member's eligibility at the time a Health Service is rendered, but shall include information necessary to contact [redacted] to determine Member's participation in the applicable Health Benefit Plan. Provider acknowledges and agrees that possession of such identification document or ability to access eligibility

information telephonically or electronically, in and of itself, does not qualify the holder thereof as a Member, nor does the lack thereof mean that the person is not a Member.

2.2 Provider Non-discrimination. Provider shall provide Health Services to Members in a manner similar to and within the same time availability in which Provider provides Health Services to any other individual. Provider will not differentiate, or discriminate against any Member as a result of his/her enrollment in a Health Benefit Plan, or because of race, color, creed, national origin, ancestry, religion, sex, marital status, age, disability, payment source, state of health, need for Health Services, status as a litigant, status as a Medicare or Medicaid beneficiary, sexual orientation, gender identity, or any other basis prohibited by law. Provider shall not be required to provide any type, or kind of Health Service to Members that he/she/it does not customarily provide to others. Additional requirements may be set forth in the applicable Participation Attachment(s).

2.3 Publication and Use of Provider Information. Provider agrees that [redacted] its Affiliates or designees may use, publish, disclose, and display, for commercially reasonable general business purposes, either directly or through a third party, information related to Provider, including but not limited to demographic information, information regarding credentialing, affiliations, performance data, and information related to Provider for transparency initiatives except for information protected by federal and state confidentiality laws.

2.4 Use of Symbols and Marks. Neither party to this Agreement shall publish, copy, reproduce, or use in any way the other party's symbols, service mark(s) or trademark(s) without the prior written consent of such other party. Notwithstanding the foregoing, the parties agree that they may identify Provider as a participant in the Network(s) in which he/she/it participates.

2.5 Submission and Adjudication of Claims. Provider shall submit, and [redacted] shall adjudicate, Claims in accordance with the applicable Participation Attachment(s), the WCS, the provider manual(s) and Regulatory Requirements. If Provider submits Claims prior to receiving notice of [redacted] approval pursuant to section 2.13, then such Claims must be submitted in accordance with prior authorization requirements, and shall be processed as out of network. [redacted] shall not make retroactive adjustments with respect to such Claims.

2.6 Payment in Full and Hold Harmless.

2.6.1 Provider agrees to accept as payment in full, in all circumstances, the applicable [redacted] Rate whether such payment is in the form of a Cost Share, a payment by [redacted] or a payment by another source, such as through coordination of benefits or subrogation. Provider shall bill, collect, and accept compensation for Cost Shares. Provider agrees to make reasonable efforts to verify Cost Shares prior to billing for such Cost Shares. In no event shall [redacted] be obligated to pay Provider or any person acting on behalf of Provider for services that are not Covered Services, or any amounts in excess of the [redacted] Rate less Cost Shares or payment by another source, as set forth above. Consistent with the foregoing, Provider agrees to accept the [redacted] Rate as payment in full if the Member has not yet satisfied his/her deductible.

2.6.2 Except as expressly permitted under Regulatory Requirements, Provider agrees that in no event, including but not limited to, nonpayment by [redacted] insolvency of [redacted] breach of this Agreement, or Claim payment denials or adjustment requests or recoupments based on miscoding or other billing errors of any type, whether or not fraudulent or abusive, shall Provider, or any person acting on behalf of Provider, bill, charge, collect a deposit from, seek compensation from, or have any other recourse against a Member, or a person legally acting on the Member's behalf, for Covered Services provided pursuant to this Agreement. Notwithstanding the foregoing, Provider may collect reimbursement from the Member for the following:

2.6.2.1 Cost Shares, if applicable;

2.6.2.2 Health Services that are not Covered Services. However, Provider may seek payment for a Health Service that is not Medically Necessary or is experimental/investigational only if Provider obtains a written waiver that meets the following criteria:

a) The waiver notifies the Member that the Health Service is likely to be deemed not Medically Necessary, or experimental/investigational;

b) The waiver notifies the Member of the Health Service being provided and the date(s) of service;

c) The waiver notifies the Member of the approximate cost of the Health Service;

d) The waiver is signed by the Member, or a person legally acting on the Member's behalf, prior to receipt of the Health Service.

2.7 Recoupment/Offset/Adjustment for Overpayments. [redacted] shall be entitled to offset and recoup an amount equal to any overpayments or improper payments made by [redacted] to Provider against any payments due and payable by [redacted] to Provider with respect to any Health Benefit Plan under this Agreement. Provider shall voluntarily refund all duplicate or erroneous Claim payments regardless of the cause, including, but not limited to, payments for Claims where the Claim was miscoded, non-compliant with industry standards, or otherwise billed in error, whether or not the billing error was fraudulent, abusive or wasteful. Upon determination by [redacted] that any recoupment, improper payment, or overpayment is due from Provider, Provider must refund the amount to [redacted] within thirty (30) days of when [redacted] notifies Provider. If such reimbursement is not received by [redacted] within the thirty (30) days following the date of such notice, [redacted] shall be entitled to offset such overpayment against any Claims payments due and payable by [redacted] to Provider under any Health Benefit Plan in accordance with Regulatory Requirements. In such event, Provider agrees that all future Claim payments applied to satisfy Provider's repayment obligation shall be deemed to have been paid in full for all purposes, including section 2.6.1. Should Provider disagree with any determination by [redacted] that Provider has received an overpayment, Provider shall have the right to appeal such determination under [redacted] procedures set forth in the provider manual, and such appeal shall not suspend [redacted] right to recoup the overpayment amount during the appeal process unless suspension of the right to recoup is otherwise required by Regulatory Requirements. [redacted] reserves the right to employ a third party collection agency in the event of non-payment.

2.8 Use of Subcontractors. Provider and [redacted] may fulfill some of their duties under this Agreement through subcontractors. For purposes of this provision, subcontractors shall include, but are not limited to, vendors and non-Participating Providers that provide supplies, equipment, staffing, and other services to Members at the request of, under the supervision of, and/or at the place of business of Provider. Provider shall provide [redacted] with thirty (30) days prior notice and obtain written approval from [redacted] of any Health Services subcontractors with which Provider may contract to perform Provider's duties and obligations under this Agreement. Failure by the provider to obtain [redacted] written approval may lead to the contract being declared null and void by [redacted] Claims submitted by the subcontractor or by the provider for services furnished by the unapproved subcontractor are considered to be improper payments and may be considered false claims. Any such improper payments may be subject to action under Federal and State false claims statutes or be subject to be recouped by [redacted] and/or [redacted] as overpayment. Provider shall remain responsible to [redacted] for the compliance of his/her/its subcontractors with the terms and conditions of this Agreement as applicable, including, but not limited to, the Payment in Full and Hold Harmless provisions herein.

2.9 Compliance with Provider Manual(s) and Policies, Programs and Procedures. Provider agrees to cooperate and comply with, [redacted] provider manual(s), and all other policies, programs and procedures (collectively "Policies") established and implemented by [redacted] applicable to the Network(s) in which Provider participates. [redacted] or its designees may modify the provider manual(s) and its Policies providing at least thirty (30) days notice to Provider in advance of the effective date of modifications thereto.

2.10 Referral Incentives/Kickbacks. Provider represents and warrants that Provider does not give, provide, condone or receive any incentives or kickbacks, monetary or otherwise, in exchange for the referral of a Member, and if a Claim for payment is attributable to an instance in which Provider provided or received an incentive or kickback in exchange for the referral, such Claim shall not be payable and, if paid in error, shall be refunded to [redacted]

2.11 Networks and Provider Panels. Provider shall be eligible to participate only in those Networks designated on the Provider Networks Attachment of this Agreement. Provider shall not be recognized as a Participating Provider in such Networks until the later of: 1) the Effective Date of this Agreement or; 2) as determined by [redacted] in its sole discretion, the date Provider has met [redacted] applicable credentialing requirements and accreditation requirements. Provider acknowledges that [redacted] may develop, discontinue, or modify new or existing Networks, products and/or programs. In addition to those Networks designated on the Provider Networks Attachment, [redacted] may also identify Provider as a Participating Provider in additional Networks, products and/or programs designated in writing from time to time by [redacted] The terms and conditions of

Provider's participation as a Participating Provider in such additional Networks, products and/or programs shall be on the terms and conditions as set forth in this Agreement unless otherwise agreed to in writing by Provider and [redacted]

In addition to and separate from Networks that support some or all of [redacted] products and/or programs (e.g., HMOand PPO), Provider further acknowledges that certain Health Services, including by way of example only, laboratory or behavioral health services, may be provided exclusively by designated Participating Providers (a "Health Services Designated Network"), as determined by [redacted] Provider agrees to refer Members to such designated Participating Providers in a Health Services Designated Network for the provision of certain Health Services, even if Provider performs such services. Notwithstanding any other provision in this Agreement, if Provider provides a Health Service to a Member for which Provider is not a designated Participating Provider in a Health Services Designated Network, then Provider agrees that he/she/it shall not be reimbursed for such services by [redacted] or the Member, unless Provider was authorized to provide such Health Service by [redacted]

2.12 Change in Provider Information. Provider shall immediately send written notice, in accordance with the Notice section of this Agreement, to [redacted] of:

2.12.1 Any legal, governmental, or other action or investigation involving Provider which could affect Provider's credentialing status with [redacted] or materially impair the ability of Provider to carry out his/her/its duties and obligations under this Agreement, except for temporary emergency diversion situations; or

2.12.2 Any change in Provider accreditation, affiliation, hospital privileges (if applicable), insurance, licensure, certification or eligibility status, or other relevant information regarding Provider's practice or status in the medical community.

2.13 Provider Credentialing and Accreditation. Provider warrants that he/she/it meets all [redacted] credentialing requirements, and accreditation requirements for the Networks in which Provider participates. A description of the applicable credentialing requirements and accreditation requirements, are set forth in the provider manual(s) and/or in the WCS. Provider acknowledges that until such time as Provider has been determined to have fully met [redacted] credentialing requirements and accreditation requirements, as applicable, Provider shall not be entitled to the benefits of participation under this Agreement, including without limitation the [redacted] Rates set forth in the WCS attached hereto.

2.14 Provider Staffing and Staff Privileges. Provider agrees to maintain professional staffing levels to meet community access standards and for applicable facilities, agrees to facilitate and to expeditiously grant admitting privileges to Participating Providers who meet Provider's credentialing standards.

2.15 Adjustment Requests. If Provider believes a Claim has been improperly adjudicated for a Covered Service for which Provider timely submitted a Claim to [redacted] Provider may submit a request for an adjustment to [redacted] in accordance with the the applicable Participation Attachment and/or provider manual(s) as incorporated into this Agreement.

2.16 Provision and Supervision of Services. In no way shall [redacted] be construed to be a provider of Health Services or responsible for, exercise control, or have direction over the provision of such Health Services. Provider shall be solely responsible to the Member for treatment, medical care, and advice with respect to the provision of Health Services. Provider agrees that all Health Services provided to Members under this Agreement shall be provided by Provider or by a qualified person under Provider's direction. Provider warrants that any nurses or other health professionals employed by or providing services for Provider shall be duly licensed or certified under applicable law. In addition, nothing herein shall be construed as authorizing or permitting Provider to abandon any Member.

2.17 Coordination of Benefits/Subrogation. Subject to Regulatory Requirements, Provider agrees to cooperate with [redacted] regarding subrogation and coordination of benefits, as set forth in Policies and the provider manual(s), and to notify [redacted] promptly after receipt of information regarding any Member who may have a Claim involving subrogation or coordination of benefits.

2.18 Cost Effective Care. Provider shall provide Covered Services in the most cost effective, clinically appropriate setting and manner. In addition, in accordance with the provider manual(s) and Policies, Provider shall utilize Participating Providers, and when Medically Necessary or appropriate, refer and transfer Members to

Participating Providers for all Covered Services, including but not limited to specialty, laboratory, ancillary and supplemental services.

2.19 Facility-Based Providers. Provider agrees to require its contracted facility-based providers or those with exclusive privileges with Provider to obtain and maintain Participating Provider status with [redacted] Until such time as facility-based providers enter into agreements with [redacted] Provider agrees to fully cooperate with [redacted] to prevent Members from being billed amounts in excess of the applicable [redacted] non-participating reimbursement for such Covered Services. Facility-based providers may include, but are not limited to, anesthesiologists, radiologists, pathologists, neonatologists, hospitalists and emergency room physicians.

2.20 Digital Guidelines. Provider shall comply with the Digital Guidelines set forth in the provider manual(s).

ARTICLE III
CONFIDENTIALITY/RECORDS

3.1 Proprietary and Confidential Information. Except as otherwise provided herein, all information and material provided by either party in contemplation of or in connection with this Agreement remains proprietary and confidential to the disclosing party. This Agreement, including but not limited to the [redacted] Rates, is [redacted] proprietary and confidential information. Neither party shall disclose any information proprietary or confidential to the other, or use such information or material except: (1) as otherwise set forth in this Agreement; (2) as may be required to perform obligations hereunder; (3) as required to deliver Health Services or administer a Health Benefit Plan; (4) to [redacted] or its designees; (5) upon the express written consent of the parties; or (6) as required by Regulatory Requirements. Notwithstanding the foregoing, either party may disclose such information to its legal advisors, lenders and business advisors, provided that such legal advisors, lenders and business advisors agree to maintain confidentiality of such information. Provider and [redacted] shall each have a system in place that meets all applicable Regulatory Requirements to protect all records and all other documents relating to this Agreement which are deemed confidential by law. Any disclosure or transfer of proprietary or confidential information by Provider or [redacted] will be in accordance with applicable Regulatory Requirements. Provider shall immediately notify [redacted] if Provider is required to disclose any proprietary or confidential information at the request of an Agency or pursuant to any federal or state freedom of information act request.

3.2 Confidentiality of Member Information. Both parties agree to comply with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Health Information Technology for Economic and Clinical Health Act ("HITECH Act"), and as both may be amended, as well as any other applicable Regulatory Requirements regarding confidentiality, use, disclosure, security and access of the Member's personally identifiable information ("PII") and protected health information ("PHI"), (collectively "Member Information"). Provider shall review all Member Information received from [redacted] to ensure no misrouted Member Information is included. Misrouted Member Information includes but is not limited to, information about a Member that Provider is not currently treating. Provider shall immediately destroy any misrouted Member Information or safeguard the Member Information for as long as it is retained. In no event shall Provider be permitted to misuse or re-disclose misrouted Member Information. If Provider cannot destroy or safeguard misrouted Member Information, Provider must contact [redacted] to report receipt of misrouted Member Information.

3.3 Network Provider/Patient Discussions. Notwithstanding any other provision in this Agreement and regardless of any benefit or coverage exclusions or limitations associated with a Health Benefit Plan, Provider shall not be prohibited from discussing fully with a Member any issues related to the Member's health including recommended treatments, treatment alternatives, treatment risks and the consequences of any benefit coverage or payment decisions made by [redacted] or any other party. In addition, nothing in this Agreement shall be construed to, create any financial incentive for Provider to withhold Covered Services, or prohibit Provider from disclosing to the Member the general methodology by which Provider is compensated under this Agreement, such as for example, whether Provider is paid on a fee for service, capitation or Percentage Rate basis. [redacted] shall not refuse to allow or to continue the participation of any otherwise eligible provider, or refuse to compensate Provider in connection with services rendered, solely because Provider has in good faith communicated with one or more of his/her/its current, former or prospective patients regarding the provisions, terms or requirements of a Health Benefit Plan as they relate to the health needs of such patient. Nothing in this section shall be construed to permit Provider to disclose [redacted] Rates or specific terms of the compensation arrangement under this Agreement.

3.4 [redacted] Access to and Requests for Provider Records. Provider and its designees shall comply with all applicable state and federal record keeping and retention requirements, and, as set forth in the provider manual(s) and/or Participation Attachment(s), shall permit [redacted] or its designees to have, with appropriate working space and without charge, on-site access to and the right to perform an Audit, examine, copy, excerpt and transcribe any books, documents, papers, and records related to Member's medical and billing information within the possession of Provider and inspect Provider's operations, which involve transactions relating to Members and as may be reasonably required by [redacted] in carrying out its responsibilities and programs including, but not limited to, assessing quality of care, complying with quality initiatives/measures, Medical Necessity, concurrent review, appropriateness of care, accuracy of Claims coding and payment, risk adjustment assessment as described in the provider manual(s), including but not limited to completion of the Encounter Facilitation Form (also called the "SOAP" note), compliance with this Agreement, and for research. In lieu of on-site access, at [redacted] request, Provider or its designees shall submit records to [redacted] or its designees via photocopy or electronic transmittal, within thirty (30) days, at no charge to [redacted] from either Provider or its designee. Provider shall make such records available to the state and federal authorities involved in assessing quality of care or investigating Member grievances or complaints in compliance with Regulatory Requirements. Provider acknowledges that failure to submit records to [redacted] in accordance with this provision and/or the provider manual(s), and/or Participation Attachment(s) may result in a denial of a Claim under review, whether on pre-payment or post-payment review, or a payment retraction on a paid Claim, and Provider is prohibited from balance billing the Member in any of the foregoing circumstances.

3.5 Transfer of Medical Records. Following a request, Provider shall transfer a Member's medical records in a timely manner, or within such other time period required under applicable Regulatory Requirements, to other health care providers treating a Member at no cost to [redacted] the Member, or other treating health care providers.

3.6 Clinical Data Sharing. [redacted] and Provider desire to collaborate by sharing data, including Member Information, to enhance certain health care operations activities, primarily to help improve quality and efficiency of health care. Each party's access to better clinical and administrative data is critical to the mutual goal of [redacted] and Provider improving health care quality as it relates to their respective Members and patients. Therefore and upon request, Provider agrees to provide data to [redacted] for treatment purposes, for payment purposes, for health care operations purposes consistent with those enumerated in the first two paragraphs of the health care operations definition in HIPAA (45 CFR 164.501), or for purposes of health care fraud and abuse detection or compliance. Such data shall be in the form of an automated transfer of Provider's Electronic Medical Record ("EMR") clinical data for closed encounters in the industry-standard Clinical Document Architecture ("CDA") format for the aforementioned uses, which shall be via Epic Payer Platform ("EPP") Clinical Data Exchange ("CDE") for providers on the Epic EMR, or materially similar connectivity interface for alternate EMR platform (e.g. Cerner, Allscripts). Automated transfer of the data shall occur ("go-live") within three (3) months after the Effective Date of this Agreement. Configuration shall be enabled such that clinical information is made available timely during and throughout inpatient encounters. Provider shall provide data as set forth in Policies or the provider manual(s), as applicable.

[*ALTERNATE*]
[redacted] and Provider desire to collaborate by sharing data, including Member Information, to enhance certain health care operations activities, primarily to help improve quality and efficiency of health care. Each party's access to better clinical and administrative data is critical to the mutual goal of [redacted] and Provider improving health care quality as it relates to their respective Members and patients. Therefore and upon request, Provider agrees to provide data to [redacted] for treatment purposes, for payment purposes, for health care operations purposes consistent with those enumerated in the first two paragraphs of the health care operations definition in HIPAA (45 CFR 164.501), or for purposes of health care fraud and abuse detection or compliance. Provider shall provide data as set forth in Policies or the provider manual(s), as applicable.

ARTICLE IV
INSURANCE

4.1 [redacted] Insurance. [redacted] shall self-insure or maintain insurance as required under applicable Regulatory Requirements to insure [redacted] and its employees, acting within the scope of their duties.

4.2 Provider Insurance. Provider shall self-insure or maintain all necessary liability and malpractice insurance in types and amounts reasonably determined by Provider, or as required under applicable Regulatory Requirements.

ARTICLE V
RELATIONSHIP OF THE PARTIES

5.1 Relationship of the Parties. For purposes of this Agreement, [redacted] and Provider are and will act at all times as independent contractors. Nothing in this Agreement shall be construed, or be deemed to create, a relationship of employer or employee or principal and agent, partnership, joint venture, or any relationship other than that of independent entities contracting with each other for the purposes of effectuating this Agreement.

5.2 Provider Representations and Warranties. Provider represents and warrants that it has the corporate power and authority to execute and deliver this Agreement on its own behalf, and on behalf of any other individuals or entities that are owned, or employed or subcontracted with or by Provider to provide services under this Agreement. Provider further certifies that individuals or entities that are owned, employed or subcontracted with Provider agree to comply with the terms and conditions of this Agreement.

ARTICLE VI
INDEMNIFICATION AND LIMITATION OF LIABILITY

6.1 Indemnification. [redacted] and Provider shall each indemnify, defend and hold harmless the other party, and his/her/its directors, officers, employees, agents, Affiliates and subsidiaries ("Representatives"), from and against any and all losses, claims, damages, liabilities, costs and expenses (including without limitation, reasonable attorneys' fees and costs) arising from third party claims resulting from the indemnifying party's or his/her/its Representative's failure to perform the indemnifying party's obligations under this Agreement, and/or the indemnifying party's or his/her/its Representative's violation of any law, statute, ordinance, order, standard of care, rule or regulation. The obligation to provide indemnification under this Agreement shall be contingent upon the party seeking indemnification providing the indemnifying party with prompt written notice of any claim for which indemnification is sought, allowing the indemnifying party to control the defense and settlement of such claim, provided however that the indemnifying party agrees not to enter into any settlement or compromise of any claim or action in a manner that admits fault or imposes any restrictions or obligations on an indemnified party without that indemnified party's prior written consent which will not be unreasonably withheld, and cooperating fully with the indemnifying party in connection with such defense and settlement.

6.2 Limitation of Liability. Regardless of whether there is a total and fundamental breach of this Agreement or whether any remedy provided in this Agreement fails of its essential purpose, in no event shall either of the parties hereto be liable for any amounts representing loss of revenues, loss of profits, loss of business, the multiple portion of any multiplied damage award, or incidental, indirect, consequential, special or punitive damages, whether arising in contract, tort (including negligence), or otherwise regardless of whether the parties have been advised of the possibility of such damages, arising in any way out of or relating to this Agreement. Further, in no event shall [redacted] or its Affiliates be liable to Provider for any extracontractual damages relating to any claim or cause of action assigned to Provider by any person or entity.

ARTICLE VII
DISPUTE RESOLUTION AND ARBITRATION

7.1 Dispute Resolution. All disputes between [redacted] and Provider arising out of or related in any manner to this Agreement shall be resolved using the dispute resolution and arbitration procedures as set forth below. Provider shall exhaust any other applicable provider appeal/provider dispute resolution procedures under this Agreement and any applicable exhaustion requirements imposed by Regulatory Requirements as a condition precedent to Provider's right to pursue the dispute resolution and arbitration procedures as set forth below.

7.1.1 In order to invoke the dispute resolution procedures in this Agreement, a party first shall send to the other party a written demand letter that contains a detailed description of the dispute and all relevant underlying facts, a detailed description of the amount(s) in dispute and how they have been calculated and any other information that the [redacted] provider manual(s) may require Provider to submit with respect to such dispute. If the total amount in dispute as set forth in the demand letter is less than one million dollars ($1,000,000), exclusive of interest, costs, and attorneys' fees, then within

twenty (20) days following the date on which the receiving party receives the demand letter, representatives of each party's choosing shall meet to discuss the dispute in person or telephonically in an effort to resolve the dispute. If the total amount in dispute as set forth in the demand letter is one million dollars ($1,000,000) or more, exclusive of interest, costs, and attorneys' fees, then within ninety (90) days following the date of the demand letter, the parties shall begin the mediation process in an effort to resolve the dispute unless both parties agree in writing to waive the mediation requirement. The parties shall mutually agree upon a mediator, and failing to do so, the parties will review the list of mediators under “health care” on the Judicial Arbitration and Mediation Services ("JAMS") website and attempt to reach agreement on a mediator. Absent agreement, the parties will request JAMS to randomly produce a strike list of potential mediators for the parties to choose from. If there is no consensus via the striking process JAMS shall be authorized to appoint a mediator.

7.2 Arbitration. Any dispute within the scope of subsection 7.1.1 that remains unresolved at the conclusion of the applicable process outlined in subsection 7.1.1 shall be resolved by binding confidential arbitration in the manner as set forth below. Except to the extent as set forth below, the arbitration shall be conducted pursuant to the JAMS Comprehensive Arbitration Rules and Procedures, provided, however, that the parties may agree in writing to further modify the JAMS Comprehensive Arbitration Rules and Procedures. The parties agree to be bound by the findings of the arbitrator(s) with respect to such dispute, subject to the right of the parties to appeal such findings as set forth herein. No arbitration demand shall be filed until after the parties have completed the applicable dispute resolution efforts described inthis Article. If the dispute resolution efforts described above cannot be completed within the deadlines specified for such efforts despite the parties' good faith efforts to meet such deadlines, such deadlines may be extended as necessary upon mutual agreement of the parties. Enforcement of this arbitration clause, including the waiver of class actions, shall be determined under the Federal Arbitration Act ("FAA"), including the FAA's preemptive effect on state law. The parties agree that the arbitration shall be conducted on a confidential basis pursuant to Rule 26 of the JAMS Comprehensive Arbitration Rules and Procedures. Subject to any disclosures that may be required or requested by Other Payors or under Regulatory Requirements, the parties further agree that they shall maintain the confidential nature of the arbitration, including without limitation, the existence of the arbitration, information exchanged during the arbitration, and the award of the arbitrator(s). Nothing in this provision, however, shall preclude either party from disclosing any such details regarding the arbitration to its accountants, auditors, brokers, insurers, reinsurers or retrocessionaires.

7.2.1 Location of Arbitration. The arbitration hearing shall be held in the city and state in which the [redacted] office identified in the address block on the signature page of this Agreement is located, except that if there is no address block on the signature page, then the arbitration hearing shall be held in the city and state in which the [redacted] entity that is a party to this Agreement has its principal place of business. Notwithstanding the foregoing, both parties can agree in writing to hold the arbitration hearing in some other location.

7.2.2 Selection and Replacement of Arbitrator(s). If the total amount in dispute is less than two million dollars ($2,000,000), exclusive of interest, costs, and attorneys' fees, the dispute shall be decided by a single arbitrator who is agreed upon in writing by the parties or selected, and replaced when required, in the manner described in the JAMS Comprehensive Arbitration Rules and Procedures. If the total amount in dispute is two million dollars ($2,000,000) or more, exclusive of interest, costs, and attorneys' fees, the dispute shall be decided by an arbitration panel consisting of three (3) arbitrators, unless the parties agree in writing that the dispute shall be decided by a single arbitrator.

7.2.3 Appeal. If the total amount of the arbitration award is three million dollars ($3,000,000) or more, inclusive of interest, costs, and attorneys' fees, the parties shall have the right to appeal the decision of the arbitrator(s) pursuant to the JAMS Optional Arbitration Appeal Procedure. An aribitration award or decision that is appealed shall not be enforceable while the appeal is pending. In reviewing a decision of the arbitrator(s), the appeal panel shall apply the same standard of review that a United States Court of Appeals would apply in reviewing a similar decision issued by a United States District Court in the jurisdiction in which the arbitration hearing was held.

7.2.4 Waiver of Certain Claims. The parties, on behalf of themselves and those that they may now or hereafter represent, each agree to and do hereby waive any right to join or consolidate claims in arbitration by or against other individuals or entities or to pursue, on a class basis, any dispute; provided however, if there is a dispute regarding the applicability or enforcement of the waiver provision in this subsection 7.2.4, that dispute shall be decided by a court of competent jurisdiction. If a court of competent jurisdiction determines that such waiver is unenforceable for any reason with

respect to a particular dispute, then the parties agree that section 7.2 shall not apply to such dispute and that such dispute shall be decided instead in a court of competent jurisdiction.

7.2.5 Limitations on Injunctive Relief. The parties recognize that in the event of a breach by either party of any obligations under this Agreement or other violations of the other party's rights in connection with this Agreement, the damage caused, if any, is not irreparable or sufficient to entitle the other party to injunctive relief. The parties, on behalf of themselves and those that they may now or hereafter represent, each agree to waive their right to seek injunctive relief. In the event of any conflict or inconsistency between this provision and the JAMS Comprehensive Arbitration Rules and Procedures, this provision shall govern. If any portion of this provision is limited, voided, or found unenforceable for any reason, then the remainder of this provision shall remain enforceable and the parties acknowledge and agree that any claim for injunctive relief is subject to this Dispute Resolution and Arbitration Article. Any injunctive relief sought against the other party or awarded by the arbitratior(s) shall be limited to the conduct or specific issues relevant to the parties to the arbitration, shall not be sought for the benefit of individuals or entities who are not parties to the arbitration, and the enjoined party shall have a right to appeal such injunction per the JAMS Optional Arbitration Appeal Procedure.

7.3 Attorney's Fees and Costs. The fees and costs of mediation and arbitration (e.g. fee of the mediator, fee of the arbitrator(s), JAMS fees if any) will be shared equally between the parties. Each party shall be responsible for the payment of its own specific fees and costs (e.g. the party's own attorney's fees, the fees of the party selected arbitrator, etc.) and any costs associated with conducting the mediation or arbitration that the party chooses to incur (e.g. expert witness fees, depositions, etc.). Notwithstanding this provision, the arbitrator may issue an order in accordance with Federal Rule of Civil Procedure Rule 11, or in conjunction with a party's offer of judgement in accordance with Federal Rules of Civil Procedure Rule 68.

ARTICLE VIII
TERM AND TERMINATION

8.1 Term of Agreement. This Agreement shall commence at 12:01 AM on the Effective Date for a term of one (1) year, and shall continue automatically in effect thereafter for consecutive one (1) year terms unless otherwise terminated as provided herein.

8.2 Termination Without Cause. Either party may terminate this Agreement without cause at any time by giving at least one hundred eighty (180) days prior written notice of termination to the other party. Notwithstanding the foregoing, should a Participation Attachment(s) contain a longer without cause termination period, the Agreement shall continue in effect only for such applicable Participation Attachment(s) until the termination without cause notice period in the applicable Participation Attachment(s) ends.

8.3 Breach of Agreement. Except for circumstances giving rise to the Immediate Termination section, if either party fails to comply with or perform when due any material term or condition of this Agreement, the other party shall notify the breaching party of its breach in writing stating the specific nature of the material breach, and the breaching party shall have thirty (30) days to cure the breach. If the breach is not cured to the reasonable satisfaction of the non-breaching party within said thirty (30) day period, the non-breaching party may terminate this Agreement by providing written notice of such termination to the other party. The effective date of such termination shall be no sooner than sixty (60) days after such notice of termination.

8.4 Immediate Termination.

8.4.1 This Agreement or any Participation Attachment(s) may be terminated immediately by [redacted] if:

8.4.1.1 Provider commits any act or conduct for which his/her/its license(s), permit(s), or any governmental or board authorization(s) or approval(s) necessary for business operations or to provide Health Services are lost or voluntarily surrendered in whole or in part; or

8.4.1.2 Provider commits fraud or makes any material misstatements or omissions on any documents related to this Agreement which Provider submits to [redacted] or to a third party; or

8.4.1.3 Provider files a petition in bankruptcy for liquidation or reorganization by or against Provider, if Provider becomes insolvent, or makes an assignment for the benefit of its creditors without [redacted] written consent, or if a receiver is appointed for Provider or its property; or

8.4.1.4 Provider's insurance coverage as required by this Agreement lapses for any reason; or

8.4.1.5 Provider fails to maintain compliance with [redacted] applicable credentialing requirements, accreditation requirements; or

8.4.1.6 [redacted] reasonably believes based on Provider's conduct or inaction, or allegations of such conduct or inaction, that the well-being of patients may be jeopardized; or

8.4.1.7 Provider has been abusive to a Member, an [redacted] employee or representative; or

8.4.1.8 Provider and/or his/her/its employees, contractors, subcontractors, or agents are ineligible, excluded, suspended, terminated or debarred from participating in a Medicaid, Medicare, and/or SCHIP Program pursuant to Sections 1128 or 1156 of the Social Security Act and 42 CFR 455.101, and in the case of an employee, contractor, subcontractor or agent, Provider fails to remove such individual from responsibility for, or involvement with, the Provider's business operations related to this Agreement, or if Provider has voluntarily withdrawn his/her/its participation in any Government Program as the result of a settlement agreement; or

8.4.1.9 Provider is convicted or has been finally adjudicated to have committed a felony or misdemeanor, other than a non-DUI related traffic violation.

8.4.2 This Agreement may be terminated immediately by Provider if:

8.4.2.1 [redacted] commits any act or conduct for which its license(s), permit(s), or any governmental or board authorization(s) or approval(s) necessary for business operations are lost or voluntarily surrendered in whole or in part; or

8.4.2.2 [redacted] files for bankruptcy, or if a receiver is appointed.

8.4.2.3 [redacted] commits fraud or makes any material misstatements or omission on any documents related to this Agreement which it submits to Provider or to a third party.

8.4.2.4 [redacted] insurance coverage as required by this Agreement lapses for any reason.

8.5 Partial Termination of Participating Providers. [redacted] shall be entitled to terminate this Agreement as it applies to one or a number of Participating Providers under the terms of this Article VIII, without terminating the Agreement in its entirety, and in such case, the Agreement shall continue in full force and effect in connection with Provider and/or any and all Participating Providers as to which the Agreement has not been terminated. Notwithstanding the foregoing, [redacted] reserves the right to terminate Participating Provider(s) from any or all Network(s) under the terms of this Article VIII while continuing the Agreement for the remaining Participating Provider(s).

8.6 Transactions Prior to Termination. Except as otherwise set forth in this Agreement, termination shall have no effect on the rights and obligations of the parties arising out of any transaction under this Agreement occurring prior to the date of such termination.

8.7 Continuation of Care Upon Termination. If this Agreement or any Participation Attachment terminates for any reasons other than one of the grounds set forth in the "Immediate Termination" section, then Provider shall, at [redacted] discretion, continue to provide Covered Services to all designated Members under this Agreement or any terminating Participation Attachment, as applicable, in accordance with Regulatory Requirements. During such continuation period, Provider agrees to: (i) accept reimbursement from [redacted]

for all Covered Services furnished hereunder in accordance with this Agreement and at the rates set forth in the WCS attached hereto; and (ii) adhere to [redacted] Policies, including but not limited to, Policies regarding quality assurance requirements, referrals, pre-authorization and treatment planning.

8.8 Survival. The provisions of this Agreement set forth below shall survive termination or expiration of this Agreement or any Participation Attachment(s):

8.8.1 Publication and Use of Provider Information;

8.8.2 Payment in Full and Hold Harmless;

8.8.3 Recoupment/Offset/Adjustment for Overpayments;

8.8.4 Confidentiality/Records;

8.8.5 Indemnification and Limitation of Liability;

8.8.6 Dispute Resolution and Arbitration;

8.8.7 Continuation of Care Upon Termination; and

8.8.8 Any other provisions required in order to comply with Regulatory Requirements.

ARTICLE IX
GENERAL PROVISIONS

9.1 Amendment. Except as otherwise provided for in this Agreement, [redacted] retains the right to amend this Agreement, any attachments or addenda by making a good faith effort to provide notice to Provider at least thirty (30) days in advance of the effective date of the amendment. Except to the extent that [redacted] determines an amendment is necessary to effectuate Regulatory Requirements, if Provider objects to the amendment prior to its effective date, then Provider has the right to terminate this Agreement, and such termination shall take effect on the later of the amendment effective date identified by [redacted] or one hundred eighty (180) days from the date Provider has provided notice of his/her/its intention to terminate the Agreement pursuant to this section. Failure of Provider to provide such notice to [redacted] within the time frames described herein will constitute acceptance of the amendment by Provider.

9.2 Assignment. This Agreement may not be assigned by Provider without the prior written consent of [redacted] Any assignment by Provider without such prior consent shall be voidable at the sole discretion of [redacted] may assign this Agreement in whole or in part. In the event of a partial assignment of this Agreement by [redacted] the obligations of the Provider shall be performed for [redacted] with respect to the part retained and shall be performed for [redacted] assignee with respect to the part assigned, and such assignee is solely responsible to perform all obligations of [redacted] with respect to the part assigned. The rights and obligations of the parties hereunder shall inure to the benefit of, and shall be binding upon, any permitted successors and assigns of the parties hereto.

9.3 Scope/Change in Status.

9.3.1 [redacted] and Provider agree that this Agreement applies to Health Services rendered by Provider at the Provider's location(s) on file with [redacted] may, in its discretion, limit this Agreement to Provider's locations, operations, business or corporate form, status or structure in existence on the Effective Date of this Agreement and prior to the occurrence of any of the events set forth in subsections 9.3.1.1 – 9.3.1.5. Unless otherwise required by Regulatory Requirements, Provider shall provide at least ninety (90) days prior written notice of any such event.

9.3.1.1 Provider (a) sells, transfers or conveys his/her/its business or any substantial portion of his/her/its business assets to another entity through any manner including but not limited to a stock, real estate or asset transaction or other type of transfer; (b) is otherwise acquired or controlled by any other entity through any manner, including but not limited

to purchase, merger, consolidation, alliance, joint venture, partnership, association, or expansion; or

9.3.1.2 Provider transfers control of his/her/its management or operations to any third party, including Provider entering into a management contract with a physician practice management company or with another entity which does not manage Provider as of the Effective Date of this Agreement, or there is a subsequent change in control of Provider's current management company; or

9.3.1.3 Provider acquires or controls any other medical practice, facility, service, beds or entity; or

9.3.1.4 Provider changes his/her/its locations, business or operations, corporate form or status, tax identification number, or similar demographic information; or

9.3.1.5 Provider creates or otherwise operates a licensed health maintenance organization or commercial health plan (whether such creation or operation is direct or through a Provider affiliate).

9.3.2 Notwithstanding the termination provisions of Article VIII, and without limiting any of [redacted] rights as set forth elsewhere in this Agreement, [redacted] shall have the right to terminate this Agreement by giving at least sixty (60) days written notice to Provider if [redacted] determines, that as a result of any of the transactions listed in subsection 9.3.1, Provider cannot satisfactorily perform the obligations hereunder, or cannot comply with one or more of the terms and conditions of this Agreement, including but not limited to the confidentiality provisions herein; or [redacted] elects in its reasonable business discretion not to do business with Provider, the successor entity or new management company, as a result of one or more of the events as set forth in subsection 9.3.1.

9.3.3 Provider shall provide [redacted] with thirty (30) days prior written notice of:

9.3.3.1 Addition or removal of individual provider(s) who are employed or subcontracted with Provider, if applicable. Any new individual providers must meet [redacted] credentialing requirements prior to being designated as a Participating Provider; or

9.3.3.2 A change in mailing address.

9.3.4 If Provider is acquired by, acquires or merges with another entity, and such entity already has an agreement with [redacted] will determine in its sole discretion which Agreement will prevail.

9.4 Definitions. Unless otherwise specifically noted, the definitions as set forth in Article I of this Agreement will have the same meaning when used in any attachment, the provider manual(s) and Policies.

9.5 Entire Agreement. This Agreement, exhibits, attachments, appendices, and amendments hereto, and the provider manual(s), together with any items incorporated herein by reference, constitute the entire understanding between the parties and supersedes all prior oral or written agreements between them with respect to the matters provided for herein. This Agreement incorporates by reference all Regulatory Requirements, [redacted] rules and regulations, consent decrees or court orders, as applicable to the services under this Agreement and revisions of such laws, regulations, consent decrees or court orders, as applicable to the services under this Agreement shall automatically be incorporated into this Agreement, as they become effective. In addition, if there is an inconsistency between the terms of this Agreement and the terms provided in any exhibits, attachments, appendices, or amendments to this Agreement, then the terms provided in the applicable Participation Attachment shall govern.

9.6 Force Majeure. Neither party shall be deemed to be in violation of this Agreement if such party is prevented from performing any of his/her/its obligations hereunder due to natural or man-made disasters, including fire, flood, earthquake, terrorism, or any similar unforeseeable act beyond its reasonable control, acts of any public enemy, statutory or other laws, regulations, rules, orders, or actions of the federal, state, or local government or any agency thereof.

9.7 Compliance with Regulatory Requirements. [redacted] and Provider agree to comply with all applicable Regulatory Requirements, as amended from time to time, relating to their obligations under this Agreement,

and maintain in effect all permits, licenses and governmental and board authorizations and approvals as necessary for business operations. Provider warrants that as of the Effective Date, he/she/it is and shall remain licensed and certified for the term of this Agreement in accordance with all Regulatory Requirements (including those applicable to utilization review and Claims payment) relating to the provision of Health Services to Members. Provider shall supply evidence of such licensure, compliance and certifications to [redacted] upon request. If there is a conflict between this section and any other provision in this Agreement, then this section shall control.

9.7.1 In addition to the foregoing, Provider warrants and represents that at the time of entering into this Agreement, neither he/she/it nor any of his/her/its employees, contractors, subcontractors, principals or agents are ineligible, excluded, suspended terminated or debarred from participating in a Medicaid, Medicare, and/or SCHIP Program ("Ineligible Person") pursuant to Sections 1128 or 1156 of the Social Security Act and 42 CFR 455.101. Provider shall remain continuously responsible for ensuring that his/her/its employees, contractors, subcontractors, principals or agents are not Ineligible Persons. If Provider or any employees, subcontractors, principals or agents thereof becomes an Ineligible Person after entering into this Agreement or otherwise fails to disclose his/her/its Ineligible Person status, Provider shall have an obligation to (1) immediately notify [redacted] of such Ineligible Person status and (2) within ten (10) days of such notice, remove such individual from responsibility for, or involvement with, Provider's business operations related to this Agreement.

9.8 Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the state where [redacted] has its primary place of business, unless such state laws are otherwise preempted by federal law. However, coverage issues specific to a Health Benefit Plan are governed by the state laws where the Health Benefit Plan is issued, unless such state laws are otherwise preempted by federal law.

9.9 Intent of the Parties. It is the intent of the parties that this Agreement is to be effective only in regards to their rights and obligations with respect to each other; it is expressly not the intent of the parties to create any independent rights in any third party or to make any third party a third party beneficiary of this Agreement, except to the extent specified in the Payment in Full and Hold Harmless section of this Agreement, or in a Participation Attachment(s).

9.10 Non-Exclusive Participation. None of the provisions of this Agreement shall prevent Provider or [redacted] from participating in or contracting with any provider, preferred provider organization, health maintenance organization/health insuring corporation, or any other health delivery or insurance program. Provider acknowledges that [redacted] does not warrant or guarantee that Provider will be utilized by any particular number of Members.

9.11 Notice. Any notice required to be given pursuant to the terms and provisions of this Agreement shall be in writing and shall be delivered by hand, facsimile, electronic mail, or mail. Notice shall be deemed to be effective: (a) when delivered by hand, (b) upon transmittal when transmitted by facsimile transmission or by electronic mail, (c) upon receipt by registered or certified mail, postage prepaid, (d) on the next business day if transmitted by national overnight courier, or (e) if sent by regular mail, five (5) days from the date set forth on the correspondence. Unless specified otherwise in writing by a party, [redacted] shall send Provider notice to an address that [redacted] has on file for Provider, and Provider shall send [redacted] notice to [redacted] address as set forth in the provider manual(s). Notwithstanding the foregoing, and unless otherwise required by Regulatory Requirements, [redacted] may post updates to its provider manual(s) and Policies on its web site.

9.12 Severability. In case any one or more of the provisions of this Agreement shall be invalid, illegal, or unenforceable in any respect, the remaining provisions shall be construed liberally in order to effectuate the purposes hereof, and the validity, legality and enforceability of the remaining provisions shall not in any way be affected or impaired thereby. If one or more provisions of the Agreement are invalid, illegal or unenforceable and an amendment to the Agreement is necessary to maintain its integrity, the parties shall make commercially reasonable efforts to negotiate an amendment to this Agreement and any attachments or addenda to this Agreement which could reasonably be construed not to contravene such statute, regulation, or interpretation. In addition, if such invalid, unenforceable or materially affected provision(s) may be severed from this Agreement and/or attachments or addenda to this Agreement without materially affecting the parties' intent when this Agreement was executed, then such provision(s) shall be severed rather than terminating the Agreement or any attachments or addenda to this Agreement.

9.13 Waiver. Neither the waiver by either of the parties of a breach of any of the provisions of this Agreement, nor the failure of either of the parties, on one or more occasion, to enforce any of the provisions of this Agreement, shall thereafter be construed as a waiver of any subsequent breach of any of the provisions of this Agreement.

9.14 Construction. This Agreement shall be construed without regard to any presumption or other rule requiring construction against the party causing this Agreement to be drafted.

9.15 Counterparts and Electronic Signatures.

9.15.1 This Agreement and any amendment hereto may be executed in two (2) or more counterparts, each of which shall be deemed to be an original and all of which taken together shall constitute one and the same agreement.

9.15.2 Either party may execute this Agreement or any amendments by valid electronic signature, and such signature shall have the same legal effect of a signed original.

Each party warrants that it has full power and authority to enter into this Agreement and the person signing this Agreement on behalf of either party warrants that he/she has been duly authorized and empowered to enter into this Agreement.

THIS AGREEMENT CONTAINS A BINDING ARBITRATION PROVISION WHICH MAY BE ENFORCED BY THE PARTIES

Provider shall be designated as a Participating Provider in the Networks set forth on the Provider Network Attachment on the later of: (1) the Effective Date of this Agreement or; (2) as determined by [redacted] in its sole discretion, the date Provider has met applicable credentialing requirements and accreditation requirements.

PROVIDER LEGAL NAME ACCORDING TO W-9 FORM WITH D/B/A: _____

By: _____ _____
Signature, Authorized Representative of Provider(s) Date

Printed: _____ _____
Name Title

Address _____ _____
Street City State Zip

(Note: if any of the following is not applicable, please leave blank**)**

Phone Number: _____

[redacted] Tennessee, Inc.

[redacted] INTERNAL USE ONLY

THE EFFECTIVE DATE OF THIS AGREEMENT IS: _____

By: _____ _____
Signature, Authorized Representative of [redacted] Date

Printed: _____ _____
Name Title

PROVIDER NETWORKS ATTACHMENT for TENNESSEE

Provider shall be designated as a Participating Provider in the following Networks on the later of: 1) the Effective Date of this Agreement or; 2) as determined by [redacted] in its sole discretion, the date Provider has met applicable credentialing requirements and accreditation requirements:

Government Programs:

Health Benefit Plans issued pursuant to an agreement between [redacted] and [redacted] and/or CMS in which Members have access to a network of providers and receive benefits when they obtain Covered Services from Participating Providers. Provider participates in one or more of the following Networks which support such Health Benefit Plans:

- Medicaid Plan - TN [redacted]
- Medicaid Plan - TN CHOICES ([redacted] LTSS CHOICES HCBS)
- Medicaid Plan - TN [redacted] CoverKids
- Medicaid Plan - TN Employment & Community First CHOICES ([redacted] LTSS ECF HCBS)
- Medicaid Plan - TN Nursing Facility Services ([redacted] LTSS NF)
- Medicaid Plan- TN Intermediate Care Facility ([redacted] ICF/IID)
- Medicaid Plan- TN 1915(c) Waiver ([redacted] Waiver HCBS)
- Medicare Advantage
- Medicare Advantage Dual Plan - TN Amerivantage Dual Coordination (DSP)
- Medicare Advantage - Health Maintenance Organization (HMO) Plans
- Medicare Advantage - Fully Integrated Dual Eligible Special Needs Program (FIDE-SNP)
- Medicare Advantage - Preferred Provider Organization (MA PPO)
- Medicare Advantage - Chronic Special Needs Plan (MA CSNP)
- Medicare Advantage - Institutional Special Needs Plan (MA ISNP)

Other Programs:

- Episode-Based Retrospective Payment
- Essentials Medicare Advantage
- Freestanding Patient Centered Care Organization (FPCC)
- Primary Care Physician Risk Sharing Arrangement (Medicaid)
- Primary Care Physician Shared Savings Arrangement (Medicaid)
- Primary Care Physician Shared Savings Arrangement (Medicare)
- Primary Care Physician Risk Sharing Arrangement (Medicare)
- Tennessee Patient Centered Medical Home Participation Attachment (Medicaid)

PARTICIPATING PROVIDERS
EXHIBIT TO THE
[redacted]
PROVIDER AGREEMENT
FOR PROVIDERS WITH MULTIPLE RENDERING PROFESSIONALS/FACILITIES

This Participating Providers Exhibit ("Exhibit") is made and entered into by and between [redacted] and Provider, as agent and contracting entity, for Participating Providers set forth herein, which is hereby attached to and incorporated into the Agreement.

ARTICLE I
OBLIGATIONS OF THE PARTIES

1.1 Representations and Warranties. Provider hereby represents and warrants:

(i) that Provider has been appointed and has been duly authorized to act as agent for the Participating Providers for the purpose of binding the Participating Providers to the terms of the Agreement;

(ii) that Provider has the requisite corporate power and authority to execute and deliver the Agreement and to negotiate the terms and conditions of the Agreement for and on behalf of the Participating Providers;

(iii) that Provider shall secure legally binding and enforceable agreements with the Participating Providers, which shall, by reference, incorporate the terms and conditions of the Agreement;

(iv) that Provider shall arrange for the provision of Covered Services to Members through its network of Participating Providers;

(v) that Provider will ensure that all Participating Providers are credentialed in accordance with [redacted] credentialing Policies prior to rendering Covered Services to Members; and

(vi) that the Agreement has been duly executed and duly authorized by all necessary corporate action on the part of Provider and Participating Provider(s), and is a legal, valid and binding obligation of Provider and Participating Provider(s) enforceable against them in accordance with its terms.

1.2 Use of Provider. Notwithstanding any provision to the contrary and without limiting the applicability of the references as set forth in the opening paragraph of the Agreement, the parties acknowledge and agree that the use of "Provider" in certain sections in the Agreement and in the applicable Participation Attachment(s) shall apply to all "Participating Providers" as if such reference was specifically set forth therein.

1.3 Reimbursement. The parties acknowledge and agree that, notwithstanding any provision contained herein to the contrary, [redacted] shall reimburse the Participating Provider in accordance with the PCS; provided, however, that only one Participating Provider shall be entitled to bill/ submit a Claim for each Covered Service provided to a Member. To the extent [redacted] has paid a Participating Provider for a Covered Service, such payment shall satisfy in full [redacted] obligation to Provider and the Participating Provider with regard to such Covered Service and in no event shall [redacted] be liable in connection with such Covered Service for any additional amounts to Provider or the Participating Provider. In no event shall [redacted] pay any reimbursement for Covered Services rendered hereunder to Provider, such reimbursement for Covered Services shall be paid directly to Participating Provider(s) in accordance with the terms of the PCS.

1.4 Addition or Deletion of Participating Providers. Subject to Section 9.3 of the Agreement, any additions of Participating Providers for which a new tax identification number ("TIN") is being added to the Agreement, or deletions of a TIN from the Agreement shall require an amendment to the Agreement, unless in [redacted] sole discretion it determines that an amendment is not necessary. Notwithstanding the foregoing, an amendment shall not be necessary for routine roster updates. Provider shall provide [redacted] with a current list of all Participating Providers on a quarterly basis.

1.5 Definitions. Any capitalized terms not otherwise defined herein shall have the same meaning as such term is otherwise defined in the Agreement.

1.6 Inconsistencies. In the event of inconsistency between this Exhibit and the Agreement, this Exhibit shall control.

1.7 Participating Providers List.

Entity Name	Street Address	City	State	Zip	Tax Identification Number

PARTICIPATION ATTACHMENT TO THE

[redacted]

PROVIDER AGREEMENT FOR THE CHOICES,
EMPLOYMENT COMMUNITY FIRST AND 1915(C) WAIVER PROGRAMS

This is a Participation Attachment ("Attachment") to the [redacted] Provider Agreement ("Agreement") for the CHOICES ("CHOICES"), Employment Community First ("ECF CHOICES") and 1915(c) Waiver ("1915(c) Waiver") programs, entered into by and between [redacted] and Provider and is incorporated into the Agreement.

ARTICLE I
OBLIGATIONS OF THE PARTIES

NOW, THEREFORE, for good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree as follows.

1.1 Insurance Coverage.

1.1.1 Coverage Requirements. At all times during the term of this Attachment, Provider shall maintain professional liability insurance, including maintaining such tail or prior acts coverage necessary to avoid any gap in coverage for claims arising from incidents occurring during the term of this Attachment. Such insurance shall (i) be obtained from a carrier authorized to issue coverage in the jurisdiction in which Provider operates, except for permitted self-insurance; and (ii) maintain minimum policy limits equal to $500,000.00 in the aggregate, or such other coverage amounts as prescribed by applicable Regulatory Requirements for a program and consented to by [redacted] Provider shall maintain general liability insurance covering Provider's premises, insuring Provider against any claim of loss, liability, or damage caused by or arising out of the condition or alleged condition of said premises, or the furniture, fixtures, appliances, or equipment located therein, and if Provider operates motor vehicles in connection with Provider's services, with liability protection against any loss, liability or damage resulting from the operation of such motor vehicles by Provider, Provider's employees or agents. Such general liability insurance shall contain commercially reasonable coverage limits, or such limits as prescribed by Regulatory Requirements for a program. To the extent required by Regulatory Requirements, Provider shall maintain workers' compensation insurance for Provider's employees.

1.1.2 Evidence of Insurance. Provider shall provide [redacted] with evidence of Provider's compliance with the foregoing insurance requirements annually, or as otherwise reasonably requested by [redacted] Provider shall provide [redacted] with at least thirty (30) days prior written notice of any cancellation or non-renewal of any required coverage or any reduction in the amount of Provider's coverage, and shall secure replacement coverage as needed to meet the requirements above so as to ensure no lapse in coverage. Provider shall furnish [redacted] with a certificate of insurance evidencing such replacement coverage. Provider shall also furnish a certificate of insurance to a requesting agency upon request. Provider may maintain professional liability coverage hereunder through a self-funded insurance plan, acceptable to [redacted] provided that it maintains actuarially sound reserves related to such self-funded plan and provides on an annual basis an opinion letter from an independent actuarial firm or other proof attesting to the financial adequacy of such reserves.

1.1.3 Additional Insurance Requirements. Providers of hands-on Home Community Based Services ("HCBS") shall agree to carry adequate liability and other appropriate forms of insurance, which shall include, but are not limited to, the following listed below. Providers of assistive technology, enabling technology and PERS may carry a lesser amount of coverage that must be reasonable and approved by [redacted] and/or Department of Disability and Aging ("DDA") credentialing.

1.1.3.1 Workers' Compensation/ Employers' Liability (including all States' coverage) with a limit not less than seven hundred fifty thousand dollars ($750,000.00) per occurrence for employers' liability. Comprehensive Commercial General Liability (including personal injury & property damage, premises/operations, independent provider, contractual liability and completed operations/products coverage) with bodily injury/property damage combined single limit not

less than seven hundred fifty thousand dollars ($750,000.00) per occurrence and one million, five hundred thousand dollars ($1,500,000.00) aggregate. Automobile Coverage (including owned, leased, hired, and non-owned vehicles coverage) with a bodily injury/property damage combined single limits not less than one million dollars ($1,000,000.00).

1.1.3.2 In addition, Providers providing Covered Services to ECF CHOICES and CHOICES Members that are required to obtain automobile coverage are limited to those expected to transport Members as a component of service delivery, including the following ECF CHOICES services: individual and small group employment supports (including pre-employment services), personal assistance, supportive home care, community integration support services, community transportation, independent living skills training, community living supports, and community living supports – family model, and including the following CHOICES services: personal care, community transportation, individual employment support services, community living supports and community living supports – family model.

1.2 Adult and Children Protective Services. Provider agrees to report suspected abuse, neglect, and exploitation of adults in accordance with TCA 71-6-103 to the Tennessee Department of Human Services and to report suspected brutality, abuse, or neglect of children in accordance with TCA 37-1-403 and TCA 37-1-605 to the Tennessee Department of Children's Services.

1.3 Member Care/Supports Coordinator and Case Manager Notification. Provider shall notify a Member's Care/Support Coordinator/ Independent Support Coordinator (ISC)/ DDA Case Manager of any significant changes in the Member's needs or care, hospitalizations, emergency room visits or recommendations for additional Covered Services as outlined in the applicable [redacted] Provider Manual. [redacted] will notify the Provider in writing of all assigned Care/Support Coordinators for each CHOICES and ECF CHOICES Member assigned to them. For 1915(c) Waiver, the Support Coordination Agency or the Department of Disability and Aging (DDA) will notify the Provider in writing of all assigned Support Coordinators/DDA Case Managers for each Member assigned to them.

1.4 Reportable Event Management ("REM") Providers shall comply with applicable Government Contract rules and regulations related to Reportable Event Management as it relates to CHOICES, ECF CHOICES, and 1915(c) Waiver Members including those requirements specified in this Section and in Section A.2.15.7 of the Government Contract.

1.4.1 Provider shall report, respond to, and document for three (3) categories of reportable events: Tier 1, Tier 2, and Additional Reportable Events and Interventions, as outlined by the State Agency and DDA in the REM protocol, and as defined in the [redacted] Intellectual Disabilities Managed Long Term Services and Support ("I/DD MLTSS") Supplemental Provider Manual and/or [redacted] Provider Manual in accordance with applicable requirements as outlined within the Government Contract and federal standards.

1.4.1.1 [redacted] shall implement the REM reporting process as directed by the State Agency, to include the Reportable Event Form (REF) issued for reporting reportable events and reporting timeframes. All Tier 1 Reportable Events must be verbally reported to the DDA Abuse Hotline as soon as possible, but no later than four (4) hours after the occurrence of the event or the discovery. The provider shall submit a corresponding REF for Tier 1 Reportable Events within one (1) business day of the Hotline report. [redacted] shall also require that such providers provide initial notification to [redacted] using the REF for all Tier 2 Reportable Events within one (1) business day from the date of witnessing or discovering the Tier 2 Reportable Event.

1.4.1.2 Provider shall ensure that its staff immediately take effective steps to prevent further harm to any and all members and respond to any emergency needs of members. Excluding when an exception is granted by DDA, Providers are required to immediately remove an employee or volunteer alleged to have acted in a manner consistent with sexual abuse or physical abuse resulting in medical treatment, named in a Tier 1 Reportable Event that DDA opens for investigation, from providing direct support to any person(s) supported until DDA has

completed their investigation, either by placing the named employee or volunteer on administrative leave or in another position in which he or she does not have direct contact with, or supervisory responsibility for, a person(s). Providers may, pursuant to agency policies, choose to remove staff concerning other incidents at their discretion, pending completion of the investigation.

1.4.1.3 Provider with a reportable event shall conduct an internal reportable event investigation for a Tier 2 Reportable Event and submit a report on the investigation within the timeframe specified by [redacted]. The timeframe for submitting the completed investigation report shall be as soon as possible, may be based on the severity of the event, and, except under extenuating circumstances, shall be no more than twenty-five (25) calendar days after the anchor date of the event. [redacted] shall review the Provider's report and follow-up with the provider as prescribed by the REM protocol.

1.4.1.4 Provider shall cooperate with any investigation conducted by [redacted] or outside agencies (e.g., State Agency, Adult Protective Services (APS), Child Protective Services (CPS), and law enforcement).

1.4.1.5 Provider shall provide appropriate training and take corrective action as needed to ensure its staff, contract providers, and workers comply with reportable event requirements.

1.4.1.6 Provider shall conduct oversight, including but not limited to oversight of its staff and contracted providers, to ensure that [redacted] policies and procedures are being followed and that necessary follow-up is being conducted in a timely manner.

1.4.2 For any Reportable Event, [redacted] shall require that the Provider have supervisory staff (including clinical staff, as applicable) review the Reportable Event and determine appropriate follow up. For Reportable behavioral Events, this may include follow up with the Member's PCP or behavioral health provider, as applicable, to provide information and determine any needed treatment adjustments, follow up with the Member's Care Coordinator, Support Coordinator, Independent Support Coordinator, or DDA Case Manager regarding any needed adjustments in the Person Centered Support Plan ("PCSP"), and targeted training or assistance for agency staff who support the person. All additional Reportable Events, any medical attention provided, and follow up shall be documented in the Member's record.

1.5 Criminal Background, Registry and Exclusion Checks. In accordance with applicable Regulatory Requirements, Provider shall perform criminal background checks, registry and exclusion checks for all employed or contracted individuals providing services under this Attachment. At a minimum, background, registry, and exclusion checks shall include a check of the Tennessee Abuse Registry, Tennessee Felony Offender Registry, National and Tennessee Sexual Offender Registry, and List of Excluded Individual/Entities (LEIE), System for Award Management (SAM), and the State Agency's Terminated Provider List. Criminal background checks, registry and exclusion checks must be performed on any employee or volunteer who will have direct contact with a Member in CHOICES, ECF CHOICES, or 1915(c) waiver. All criminal background, registry and exclusion checks required in this Section must be completed prior to any such person having direct contact with a CHOICES, ECF CHOICES, or 1915(c) waiver Member. Any employee or volunteer supporting CHOICES, ECF CHOICES, or 1915(c) waiver Members who will not have direct contact with these Members must have required registry and exclusion checks completed prior to beginning this support. Unless federal or state laws prohibit individuals with certain criminal records from holding particular positions or engaging in certain occupations, an individual whose background, registry or exclusion check reveals past criminal conduct shall be given an opportunity to undergo an individualized assessment in accordance with the applicable laws and legal guidance, including, but not limited to CRA Section A.2.9.9.6 and [redacted] Rule 1200-13-01.05.

1.6 Government Contract Requirements.

1.6.1 Provider agrees to notify [redacted] in writing at least sixty (60) days in advance of the proposed date of termination of services when the Provider is no longer willing or able to provide Covered Services to Member(s), including the reason for the decision, and will cooperate with the Member's Care Coordinator, Support Coordinator, Independent Support Coordinator, or DDA Case Manager to facilitate a seamless transition to alternate providers;

1.6.2 In the event that a Provider change is initiated for a Member, regardless of any other provision in the Agreement, the transferring Provider shall continue to provide Covered Services to the Member in accordance with the Member's PCSP, as appropriate until the Member has been transitioned to a new provider, as determined by [redacted] unless otherwise directed by [redacted] which may exceed sixty (60) days from the date of notice to [redacted] unless the Member refuses continuation of services, the Member's health and welfare would be otherwise at risk by remaining with the current Provider, or if continuing to provide Covered Services is reasonably expected to place staff that would deliver Covered Services at imminent risk of harm. [redacted] shall clearly document any Member refusal of services, and all concerns and actions taken to remediate the concerns if the welfare and safety of either the Member and/or the staff will result in services not being delivered. Prior to discontinuing service to the Member or prior to Provider termination of its the Agreement, as applicable, the Provider shall be required to:

1.6.2.1 Provide a written notification of the planned service discontinuation to the Member, his/her conservator or guardian, and his/her support/care coordinator, no less than sixty (60) days prior to the proposed date of service or Agreement termination;

1.6.2.2 Obtain [redacted] approval, in the form of a signed PCSP, to discontinue the service and cooperate with transition to any subsequent, authorized service provider as is necessary; and

1.6.2.3 Consult and cooperate with [redacted] in the preparation of a discharge plan for all Members receiving care and service from the Provider in the event of a proposed termination of service. Also, when appropriate, as part of the discharge plan, the Provider shall meet, consult and cooperate with any new providers to ensure continuity of care and as smooth a transition as possible.

1.6.3 Provider agrees that reimbursement of a Provider shall be contingent upon the satisfactory provision of Covered Services to an eligible Member in accordance with applicable Regulatory Requirements and the Member's plan of care or PCSP, as appropriate and as authorized by [redacted] and must be supported by detailed documentation of service delivery to support the amount of services billed, including at a minimum, the date, time and location of service, the specific service provided, the name of the Member receiving the service, the name of the staff person who delivered the service, the detailed tasks and functions performed as a component of each service, notes for other caregivers (whether paid or unpaid) regarding the Member or his/her needs (as applicable), and the initials or signature of the staff person who delivered the service – electronic visit verification that fully comports with the 21st Century Cures Act and State Agency requirements shall be deemed sufficient to meet this requirement;

1.6.4 Provider shall immediately report any deviations from a Member's service schedule that would affect service authorizations to the Member's support/care coordinator;

1.6.5 Provider shall use, as applicable, the electronic visit verification system (EVV) specified by the [redacted] in accordance with [redacted] requirements;

1.6.5.1 CHOICES and ECF CHOICES Providers [redacted] utilizing the electronic visit verification system are required to ensure that all employees complete and submit worker surveys upon logging out of each visit using a format and in a manner approved by the applicable State Agency.

1.6.6 Upon acceptance to provide approved Covered Services to a Member as indicated in the Member's plan of care or PCSP, as appropriate, the Provider shall ensure that it has staff sufficient to provide the Covered Service(s) authorized by [redacted] in accordance with the Member's plan of care or

PCSP, as appropriate, including the amount, frequency, duration and scope of each service in accordance with the Member's service schedule as applicable.

1.6.7 Provider shall provide back-up for their own staff if they are unable to fulfill their assignment for any reason and ensure that back-up staff meet the qualifications for the authorized service; and

1.6.8 Provider shall not require a Member to choose the Provider as a provider of multiple services as a condition of providing any service to the Member.

1.6.9 Provider shall not solicit Members to receive services from the Provider including;

1.6.9.1 Referring an individual for Provider screening and intake with the expectation that Provider enrollment occur. The Provider will be selected by the Member as the service provider; or

1.6.9.2 Communicating with existing Members via telephone, face-to-face or written communication for the purpose of petitioning the Member to change providers;

1.6.9.3 Communicating with hospitals, discharge planners or other institutions for the purposes of soliciting potential members that should instead be referred to [redacted] or Area Agency on Aging and Disability ("AAAD"), or DDA as applicable;

1.6.10 Providers shall screen their employees and contractors initially and on an ongoing monthly basis to determine whether any of them has been excluded from participation in Medicare, Medicaid, State Children's Health Insurance Program ("SCHIP") or any federal health care programs (as defined in Section 1128B(f) of the Social Security Act) and not employ or contract with an individual or entity that has been excluded or debarred. The Provider shall be required to immediately report to [redacted] any exclusion information discovered. The Provider shall be informed that civil monetary penalties may be imposed against Providers who employ or enter into contracts with excluded individuals or entities to provide items or services to Members.

1.6.11 Prohibit CHOICES, ECF CHOICES, and 1915(c) waiver providers from altering in any manner official CHOICES, ECF CHOICES, Money Follows the Person Rebalancing Demonstration ("MFP"), or 1915(c) waiver materials unless [redacted] has submitted a request to do so to the applicable State Agency and obtained prior written approval from the applicable State Agency in accordance with Section A.2.17 of the Government Contract.

1.6.12 Prohibit Providers from reproducing for its own use the program or MFP logos unless [redacted] has submitted a request to do so to the applicable State Agency and obtained prior written approval from the applicable State Agency in accordance with Section A.2.17 of the Government Contract.

1.6.13 Provider agrees to maintain compliance with the HCBS Settings Rule detailed in 42 C.F.R. § 441.301(c)(4)-(5).

1.6.14 Prior to executing the Agreement with Provider seeking Medicaid reimbursement for CHOICES, ECF CHOICES, or 1915(c) waiver HCBS, [redacted] shall verify that the Provider is compliant with the HCBS settings rule detailed in 42 C.F.R. § 441.301(c)(4)-(5). Any such determination by DDA shall satisfy this requirement. The provider agreements with a CHOICES, ECF CHOICES, or 1915(c) waiver HCBS providers shall meet the minimum requirements specified in Section A.2.12.9 of the Government Contract.

1.6.15 Provider shall submit copies of current licensure, training, and/or certification to [redacted] or to DDA as applicable.

1.6.16 [redacted] shall require that contracted providers in CHOICES, ECF CHOICES, and 1915(c) waiver are responsible for acquiring, developing, and deploying a sufficiently staffed and qualified workforce to capably deliver services to Members in a person-centered way. Upon acceptance of an authorization for services, contracted providers shall be obligated to deliver services in accordance with the PCSP, including the amount, frequency, intensity, and duration of services specified in the PCSP, and shall be responsible for arranging back-up staff to address instances when other scheduled staff are not able to deliver services as scheduled. The Provider shall, in any and all

circumstances, except Member refusal of continuation of services, instances where the Member's health and welfare would be otherwise at risk by remaining with the current provider, if continuing to provide services is reasonably expected to place staff that would deliver services at imminent risk of harm, or following termination of the Agreement, continue to provide services that maintain continuity of care to the person supported in accordance with his/her PCSP until other services are arranged and provided that are of acceptable and appropriate quality. [redacted] shall document clearly any member refusal of services, and all concerns and actions taken to remediate the concerns if the welfare and safety of either the Member and/or the worker will result in services not being delivered.

1.6.17 When there is a proposed change of ownership with any CHOICES, ECF CHOICES, or 1915(c) waiver provider, the new legal entity shall provide to the applicable State Agency documents sufficient to obtain a Medicaid ID based on appropriate documentation submitted by the new provider and any managed care organization previously contracted with the former owner or operator. [redacted] shall enter into a provider agreement with the new owner/operator. A new provider with a Medicaid ID and an executed contract with [redacted] which shall include, but not be limited to, the assumption of the previous owner's contract, a new contract with [redacted] or a single case agreement, shall be reimbursed at one hundred percent (100%) from the effective date of the change of ownership. A new provider with a Medicaid ID, but without an executed contract with [redacted] shall be reimbursed eighty percent (80%) from the effective date of the change of ownership, with a retroactive payment to the effective date of the change of ownership of an additional twenty percent (20%) due after the execution of a contract with [redacted] A new provider with a change of ownership that has not acquired a Medicaid ID shall not be reimbursed, including retroactively, until such provider acquires a Medicaid ID.

1.6.18 All CHOICES, ECF CHOICES, and 1915(c) waiver providers for whom DDA is providing quality monitoring, as specified by State Agency, shall cooperate with all quality monitoring processes and requirements, as described herein or in State Agency quality monitoring protocols.

1.6.19 The provider agreement with a CHOICES, ECF CHOICES, or 1915(c) Waiver provider to provide PERS, assistive technology, enabling technology, minor home modifications, or pest control shall meet the requirements specified in the Government Contract, Sections A.2.12.8, A.2.12.9, and A.2.12.12 except that these providers are not required to meet the following Government Contract sections: Section A.2.12.9.9 regarding emergency services; Section A.2.12.9.11 regarding delay in prenatal care; Section A.2.12.9.12 regarding CLIA; Section A.2.12.9.44 regarding hospital protocols; Section A.2.12.9.45 regarding reimbursement of obstetric care; Section A.2.12.9.58.2 regarding prior authorization of pharmacy; and Section A.2.12.9.59 regarding coordination with the PBM.

1.6.20 CHOICES and I/DD MLTSS programs Providers are required to allow DDA staff access to pertinent CHOICES and I/DD MLTSS Program Member documentation in order for DDA to perform its oversight roll (applicable in CHOICES for Reportable Event Management and Quality Monitoring for specified services).

1.6.21 CHOICES and I/DD MLTSS programs Providers shall comply with DDA investigations as prescribed by the applicable State Agency protocol.

1.6.22 All ECF CHOICES and 1915(c) waiver providers are required to ensure that:

1.6.22.1 All direct support staff (i.e., provider staff working directly with Members in ECF CHOICES, and 1915(c) waiver programs complete required pre-service training as prescribed by the applicable State Agency within thirty (30) days of hire and prior to providing direct support to Members.

1.6.23 All staff employed by contracted providers and delivering employment services to CHOICES, ECF CHOICES, or 1915(c) waiver program Members obtain certification and training pursuant to applicable State Agency's guidance and as required for compliance in these programs.

1.7 Additional Requirements. In addition to Section 1.6 and except as exempted in Section 1.6.19, all ECF CHOICES, 1915(c) Waiver providers, and all CHOICES Community Living Supports ("CLS") and Community Living Supports Family Model ("CLS-FM") providers shall include the following additional requirements:

1.7.1 Residential Providers shall develop and maintain policies concerning fire evacuation and natural disasters, including ensuring staff are knowledgeable about evacuation procedures and any available safety equipment (e.g., fire extinguishers).

1.7.2 Providers shall routinely monitor the maintenance of a sanitary and comfortable living environment and/or program site and shall develop and maintain policies for staff to identify and report any individual or systemic problems identified. Additionally, all CLS-FM providers must complete a DDA-compliant home study and a current DDA Family Model Residential Supports Initial Site Survey prior to Member placement.

1.7.3 Providers with Provider-owned vehicles (including employee-owned vehicles used to transport Members) shall develop and maintain policies to routinely inspect such vehicles, including adaptive equipment used in such vehicles, and report and resolve any deficiencies with these vehicles.

1.7.4 Providers shall designate a staff member as a Reportable Event Management Coordinator who shall be trained on Reportable Event processes by [redacted] as prescribed by the applicable State Agency. Such staff member shall be the Provider's lead for Reportable Events, be primarily responsible for tracking and analyzing Reportable Events, and be the main point of contact at the Provider agency for Reportable Events.

1.7.5 Providers shall develop and maintain a crisis intervention policy that is consistent with the applicable State Agency requirements and approved by [redacted] As applicable, policies shall include instructions for the use of psychotropic medications and behavioral safety interventions.

1.7.6 Providers shall develop and maintain a complaint resolution process, which includes, but is not limited to the following: designation of a staff member as the complaint contact person; maintenance of a complaint log; and documentation and trending of complaint activity. The Provider's policies and procedures concerning the complaint resolution process shall be available to [redacted] upon request.

1.7.7 As applicable, Providers providing assistance to Members with medication administration shall develop and maintain policies to ensure any medications are provided and administered by trained and qualified staff consistent with a physician's orders. Such Providers shall ensure that medication administration records are properly maintained, and that all medication is properly stored and accessible to Members when needed. Such Providers shall also develop and maintain policies to track and trend medication variance and omission reportable events to analyze trends and implement prevention strategies.

1.7.8 Providers shall develop and maintain policies approved by [redacted] that ensure Members are treated with dignity and respect, including training staff on person-centered practices. Such policies shall include, but are not limited to:

1.7.8.1 Ensuring Members/representatives and family are given the opportunity to participate in the selection and evaluation of their direct support staff, if applicable;

1.7.8.2 Soliciting Member/representative and family feedback on provider services;

1.7.8.3 Ensuring the Member/representative has information to make informed choices about available Covered Services;

1.7.8.4 Ensuring Members are allowed to exercise personal control and choice related to their possessions;

1.7.8.5 Supporting Members in exercising their rights;

1.7.8.6 Periodically reviewing Members' day services and promoting meaningful day activities, if applicable;

1.7.8.7 Supporting the Member in pursuing employment goals; and

1.7.8.8 Only restricting Members' rights as provided in the Member's PCSP.

1.7.9 Residential Providers shall develop and maintain policies to ensure that Members have good nutrition while being allowed to exercise personal choice and that Members' dietary and nutritional needs are met.

1.7.10 Providers shall ensure that staff have appropriate, job-specific qualifications and shall verify prior to and routinely during employment that Provider staff have all required licensure, training, and certification and submit copies of current licensure, training, and/or certification (as applicable) to [redacted] or to DDA, as applicable. Additionally, all Providers shall ensure that staff receive ongoing supervision consistent with staff job functions.

1.7.11 Providers shall ensure that the composition of the Provider board of directors or community advisor group, as applicable, reflects the diversity of the community that the Provider serves and is representative of the people served.

1.7.12 Residential Providers shall have policies and procedures to manage and protect members' personal funds that comport with all applicable the applicable State Agency policies, procedures and protocols.

1.7.13 Providers of hands on HCBS shall agree to carry adequate liability and other appropriate forms of insurance, which shall include, but is not limited to, as stated in Section 1.1 of this Attachment.

1.8 Inconsistencies. In the event of an inconsistency between terms and conditions of this Attachment and the terms and conditions as set forth in the Agreement, the terms and conditions of this Attachment shall govern. Except as set otherwise forth herein, all other terms and conditions of the Agreement remain in full force and effect.

EPISODE-BASED RETROSPECTIVE PAYMENT
PARTICIPATION ATTACHMENT TO THE
[redacted]
PROVIDER AGREEMENT

This is an Episode-Based Retrospective Payment Participation Attachment ("Attachment") to the [redacted] Provider Agreement ("Agreement"), entered into by and between [redacted] and Provider and is incorporated into the Agreement.

[redacted] shall implement Payment Reform Initiatives, including retrospective episode-based reimbursement, as required by [redacted] Provider types identified by [redacted] as Principal Accountable Providers ("PAPs") or "Quarterbacks" (QBs) are required, as a condition of participation in the [redacted] Program, to participate in such [redacted] Payment Reform Initiatives for the purposes of furthering quality improvement and reporting processes in accordance with [redacted] requirements. Episodes and quality measures defined by [redacted] will be provided within the [redacted] Provider Episode-Based Retrospective Payment Appendix Thresholds Attachment. [redacted] shall provide quarterly performance reports to Provider and Quarterbacks and shall reconcile episode performance annually.

Payment Reform Initiatives. [redacted] has adopted this Episode-Based Retrospective Payment Program, (this "Program") as part of the State of Tennessee's Health Care Innovation Initiative for the purpose of more closely aligning reimbursement with health care quality. [redacted] shall implement this Program as described in this Episode-Based Retrospective Payment Appendix (this "Appendix"), in accordance with [redacted] requirements.

Provider acknowledges the [redacted] Program is implementing an Episode of Care payment system for compensation of Providers deemed to have the greatest accountability for quality and cost of care for a patient. Providers deemed to have the greatest accountability for the quality and cost of care for a patient are "Principal Accountable Providers" or "PAPs" or "Quarterbacks".

Provider agrees that a Quarterback, as identified by [redacted] for each episode of care and as defined herein, is required by the [redacted] Program to participate and cooperate with [redacted] for purposes of furthering quality improvement and reporting processes as developed for this program and described by [redacted] Episodes and quality measures defined by [redacted] are identified in the attached [redacted] Thresholds Attachment, which is incorporated herein.

[redacted] shall provide quarterly performance reports to the Quarterback and shall reconcile episode performance annually.

Additional episodes will be identified and added as determined by [redacted] [redacted] will work with [redacted] to define the process for adding each additional episode.

SECTION I – Definitions
Acceptable Cost Threshold: The dollar amount, as determined by [redacted] to which the Quarterbacks' risk adjusted average episode cost (calculated in Section II below) for a Program Episode will be compared. The Acceptable Cost Threshold is used to determine the dollar amount of the Shared Risk Payment from the Quarterback to [redacted] and can be found on each interim and final Performance Report provided to the Quarterback. For the Acceptable Cost Threshold, the threshold represents the maximum cost in that category. Providers with a cost equal to or less than the threshold meet the threshold requirement. See thresholds attachment.

Commendable Cost Threshold: The dollar amount, as determined by [redacted] to which the Quarterback's risk adjusted average episode cost for a Program Episode will be compared. If the Quarterback meets all of the quality indicators linked to gain sharing, the commendable cost threshold is then used to the determine dollar amount of a shared savings payment from [redacted] to the Quarterback, subject to the Gain Share Limit. The dollar amount of the commendable cost threshold can be found on each interim and final Performance Report provided to the Quarterback. For the Commendable Cost Threshold, the threshold represents the maximum cost in that category. Providers with a cost equal to or less than the threshold meet the threshold requirement. See thresholds attachment.

Cost Zones: Based on the prior quarter average episode costs, as calculated in Section II below, Quarterback Zone, or Commendable Cost Zone.

Episode or Episode of care: Episodes are acute or specialized treatments a patient receives for a specified period of time. An Episode will include all the different health care services related to the treatment of one acute or specialized health care event, net of episodes excluded for clinical or operational considerations.

Episode Measurement Period ("EMP"): The measurement period for the Quality Certification Component of the program defined as including all episodes ending the 12-month period that begins on the effective date of this Appendix. Subsequently measurement periods will begin as defined by [redacted]

Episode Provider Stop-loss: A methodology that will be incorporated into the Total Episode Cost calculation that is designed to limit significant provider risk under the episode of care model. The Episode Provider Stop-loss is not intended to be a regulated stop loss or reinsurance product, but rather is a calculation integrated within the Risk Sharing component of the Program intended to provide protection from the impact of excessive Quarterback penalties.

Gain Share Limit: Calculated, as defined by [redacted] as the average of the non-adjusted cost for the five lowest costs for a valid Episode of Care that will be used to calculate any shared savings payment to the Quarterback, if all of the eligibility criteria are met.

Gain Sharing: If a Quarterback achieves a risk-adjusted average per-episode cost below the commendable threshold while meeting quality standards, then the Quarterback is eligible for Gain Sharing. Gain Sharing is savings below the commendable threshold with respect to the Gain Share Limit.

Member: A Member is a Medicaid enrollee assigned to [redacted] by the state Medicaid program. A Member is subject to retroactive disenrollment by the state, in which case such individual will not be considered a member for any period as of the effective date of such disenrollment.

Performance Report: The interim or final report with respect to a given Episode Measurement Period that shows, on an interim or final basis, the Quarterback's performance results, and the other information described in this Appendix.

Principal Accountable Provider ("PAP" or "Quarterback"): The Provider deemed to have the greatest accountability for the quality and cost of care for a patient. Quarterbacks are designated for each episode based on the degree of influence they have over clinical decisions and the care delivered.

Quality Certification Component: The program component that measures the quality performance of the Quarterback. The quarterly quality certification is a prerequisite for becoming and remaining eligible for Gain Sharing. The quality certification designation will apply to those Quarterbacks that have a score meeting or exceeding [redacted] defined threshold levels for Quality Indicators Linked to Gain Sharing.

Quality Indicators Linked to Gain Sharing: The set of indicators that will be used for determination of quality certification of each episode. These quality indicators will be based on clinically appropriate and evidence-based practice. Applicable quality indicator definitions and measurement specifications will be published with each episode. The thresholds for Quality Indicators Linked to Gain Sharing, represent the minimum score required to meet the metric. Quality results equal to or higher than the threshold are considered to have met the requirements for the measure. See thresholds attachment.

Quality Indicators Not Linked to Gain Sharing: The additional set of indicators that will be provided to each Quarterback of each episode for the purpose of quality improvement. These quality indicators will be based on clinically appropriate and evidence-based practice. Applicable quality indicator definitions and measurement specifications will be published with each episode. The thresholds for Quality Indicators Not Linked to Gain Sharing, represent the minimum score required to meet the metric. Quality results equal to or higher than the threshold are considered to have met the requirements for the measure.

Risk Sharing: If a Quarterback's risk adjusted average per-episode cost is more than the acceptable threshold, no gain share payment is earned, and the risk will be shared with [redacted] Risk sharing is the cost above the Acceptable Threshold.

Total Episode Cost: The total episode cost is the sum of the amount that reflects the totality of all costs for claims identified for all [redacted] Members included in the episode.

Valid Episode of Care: Medicaid Covered Services provided by one or more Providers over a period of time related to a particular condition or procedure, including clinically related Medicaid Covered Services, as pre-defined by [redacted] An episode will include all the different health care services related to the treatment of one acute or specialized health care event, net of episodes excluded for clinical or operational considerations.

Section II - Gain/Risk Share Pay Component

Risk Sharing Amount: If the risk-adjusted average episode cost is more than the acceptable cost threshold, no gain share payment is earned, and the risk will be shared with [redacted] The Quarterback, without regard to whether the eligibility criteria are met, is required to pay their portion of any deficit to [redacted] If the final performance report shows that the Provider owes money to [redacted] the final report will serve as an invoice to the Provider, and the Provider will need to issue their payment to [redacted] within 30 days of the date of this notification. If [redacted] does not receive payment, [redacted] reserves the right to offset claim payments for money owed.

Steps for submitting payment:

Checks should be made out to [redacted] and mailed to the address below. Include as a note on the remit check that this payment is for the Episodes of Care program and the name of the Episode(s) the risk share amount is referencing:
[redacted] Tennessee Attn: Finance Department- Episodes of Care Risk Share Payment
22 Century Blvd., Suite 310
Nashville, TN 37214

Gain Sharing Amount: If the risk-adjusted total episode cost is less than the acceptable cost threshold for the episode measurement period, the Quarterback's unadjusted payment by [redacted] will be calculated according to the specifications below. The delivery date for checks to Providers is within 30 days of the date of this notification. Providers who will receive a gain-share payment will receive a paper check. This check will be sent to the remittance address on file with [redacted] and/or the requested mailing address of the Provider.

Total Episode Cost = All associated claims submitted and paid during an episode measurement period.

Total # of valid episodes = Net of episodes excluded for clinical or operational considerations

Avg. episode cost (non adj.) =
Raw claims average =
Total episode cost ÷ total # of valid episodes

Risk adjustment factor (avg.) =
The adjustment needed to insure that the average risk score across all episodes for [redacted] is equal to 1.00
Average adjustment to raw claims to account for clinical variability

Avg. episode cost (risk adj.) =
Adjusted cost per episode =
Average episode cost non-adjusted ÷ the risk adjustment factor

Total Gain Sharing generated =
Total difference in adjusted cost vs. commendable cost =
Difference between average episode cost risk-adjusted and commendable cost × total # of valid episodes

Total Risk Sharing penalty =
Total difference in adjusted cost vs. not acceptable cost =
Difference between acceptable cost and average episode cost risk-adjusted × total # of valid episodes

SECTION III – Notification

[redacted] shall notify Quarterbacks to the availability of their quarterly performance and/or preview EOC reports via email, fax, or letter. The Quarterback will be asked to respond to [redacted] confirming receipt of the notification, confirming their preferred delivery method, and contact person. Quarterbacks must provide their most up-to-date contact information as this is essential for Providers to receive alerts about any changes to EOC reports or newly released reports in a timely manner. In the initial communication to Quarterbacks, [redacted] shall provide 1) instructions on how to access full reports, and 2) how to share and update electronic contact information.

Section IV - Reporting Component

The Quarterback's performance will be measured for each episode in reports. **Average episode cost (risk adjusted)** will be compared with pre-determined thresholds. Based on performance, [redacted] will then reconcile total payment with each Quarterback. This performance summary will provide a detailed picture of the quality indicators of a Quarterback that go into the Quarterback's quality outcomes and how the Quarterback is performing relative to other Quarterbacks in this episode.

Cost ranges for commendable, acceptable, and unacceptable costs will also be included in the report. If the Quarterback's costs are considered unacceptable, the Quarterback will be subject to risk sharing. If the Quarterback's costs are in the acceptable range, there will be neither gain nor risk sharing. If the Quarterback's costs are within the commendable range, the Quarterback will be eligible for gain sharing if the Quarterback met required quality metrics.

Section V - Eligibility - Quality Certification

A. [redacted] will make available to the Quarterback an interim performance report on a quarterly basis. This report is designed to provide a summary and to list those Members that are included in any of the quality indicators measurements for each valid episode. This report will detail the quality indicators linked to gain/risk sharing.

B. Quarterbacks who do not meet the benchmarks for quality indicators linked to Gain Sharing are ineligible for Gain Sharing. In addition, Quarterbacks whose average episode costs fall above the acceptable threshold are responsible for a portion of those costs. Quarterbacks whose average cost falls between the commendable and acceptable thresholds receive no gain share and pay no risk share.

All Quarterbacks involved in an episode of care will be paid in accordance with their Agreement for Medicaid Covered Services rendered.

Section VI - Quarterly Reconciliations and Payments

Quarterly performance reports are for informational purposes, and only the final performance report for a given performance period will be used to determine any shared gain/risk payments.

A. **Risk Share Payment**: Payment equal to 50% of the total Risk Shared. See Section II for calculations.

B. **Gain Share Payment**: Payment equal to 50% of the total Gain Shared. See Section II for calculations.

C. **Shared Risk Payment Due Date**: [redacted] or Quarterback, as applicable, will pay to the other party the shared risk payment, if any, within a predetermined, agreed upon number of days after [redacted] provides the final Quarterback Performance Report.

Section VII - Regulatory Requirements

A. The parties acknowledge and agree that: (i) the compensation set forth in the Agreement, including this Appendix, does not reward Quarterbacks for limiting the provision of any medically necessary services to any patients; and (ii) nothing contained in the Agreement, including this Appendix, will be construed in any manner as creating an obligation or inducement to limit the provision of any medically necessary services to be provided by Quarterbacks. Provider, on behalf of itself and/or its assigned Quarterbacks, covenants and agrees that Quarterbacks will immediately report to [redacted] any physician, health care professional or facility whom a Quarterback believes, or has reason to believe, may have limited or denied, or attempted to limit or deny, medically necessary or clinically appropriate care to one or more Members. Any such limitation, denial, or attempt, as determined by [redacted] in its sole discretion, will be grounds for immediate termination of this Appendix and will be deemed a material breach under the Agreement for purposes of termination of the Agreement; and notwithstanding anything in this Appendix to the contrary, no further payments will be made under this Appendix in the event of such termination. In its sole discretion, [redacted] may elect instead to exclude the individual physician, health care professional or facility from participating under this Appendix immediately upon written notice to such Quarterback. Provider acknowledges and agrees that [redacted] is relying upon the foregoing representations and covenants of Quarterback in connection with Quarterback's participation in the Program described in this Appendix.

B. Provider, on behalf of itself and/or its assigned Quarterbacks, represents and warrants that, to the extent the Provider distributes any portion of any incentive payments to or from [redacted] under this Appendix to PCPs, Quarterback (i) will make such distribution(s) in compliance with CMS rules and regulations and (ii) will make any such distributions on a per capita basis to all professionals who have been PCPs for at least one year, and shall not limit distributions to any particular group of individual physicians or professionals; and (iii) will limit each such payment so that no PCP receives an amount that would result in substantial financial risk as defined by the PIP Regulations. If requested by [redacted] Quarterbacks will provide [redacted] with a description of their physician compensation arrangements and such other information related to such payments as needed to demonstrate the Quarterback's compliance with CMS and other applicable rules and regulations and this Section.

C. If this Appendix is required to be filed with one or more federal, state, or local governmental authorities, [redacted] will be responsible for each such filing. If, following any such filing, the governmental authority requests

changes to this Appendix, Provider, on behalf of itself and/or its Quarterbacks, agrees to cooperate with [redacted] in preparing the response to the governmental authority.

Section VIII - Reconsideration

Regarding quarterly and performance EOC reports, if there are any concerns with data in either of these partial year reports, please contact your EOC Provider Representative within 30 days of the report notification or email wlpepisode.reporting@[redacted]com. [redacted] will then work with you to investigate the reported concerns and determine the best course of action to address the issue. This is an informal process and not part of the final report reconsideration process.

There are two levels of reconsideration for the EOC program. The first step is with [redacted] The second step is with the Tennessee Department of Commerce and Insurance (TDCI). After receiving the Final Performance Report in August and if a Quarterback has concerns regarding the program provider payment and/or metrics accuracy of the final performance report, the Quarterback will submit a formal Reconsideration request as detailed below:

Within 30 business days following the date of the final performance report notification, Providers have the right to submit a written request for reconsideration to [redacted] will review and respond within 30 business days of receipt of the reconsideration.
Steps for submitting a written reconsideration request:
Reconsideration requests need to be sent in writing to [redacted] via mail or email: Mail: [redacted] Tennessee
Attn: Provider Relations — Episodes of Care 22 Century Blvd., Suite 310
Nashville, TN 37214
Email: wlpepisode.reporting@[redacted]com
Please provide a detailed rationale to support the reconsideration request to include:

- Identification of each performance result (payment and metrics) to be reconsidered
- Identification of the contested result calculated
- A detailed explanation of why the Provider believes the determination is incorrect
- Any other relevant information to support the Provider's reconsideration request

If the Quarterback does not object in writing to a final reconsideration within 30 days following the receipt of [redacted] reconciliation report, the Quarterback will be deemed to have accepted such reconciliation.

If a Provider is dissatisfied with the result of the reconsideration process or if [redacted] fails to respond to the reconsideration request within 30 days from the received date of the payment dispute, the Provider may submit a Provider Complaint about specific claims or an episode directly to TDCI. This is an option instead of starting the independent review process which is detailed below. To submit a Provider Complaint to TDCI the Provider will access the Provider Complaint Form for the Episodes of Care program on the State website, https://www.tn.gov/content/dam/tn/commerce/documents/tcoversight/forms/PROVIDER_COMPLAINT_FORM_EOC_IN2002_092921.pdf. . Instructions for completing the form can be obtained on the State website,https://www.tn.gov/commerce/[redacted]oversight/mco-dispute-resolution/provider-complaint-process.html.
TDCI will process the complaint within a few days of receipt and allow [redacted] 30 calendar days to investigate and respond accordingly. This process is estimated to take no longer than 40 days. However, please note that unlike the independent review protocol, this process is informal and not binding for either party.

The Provider may also submit concerns to the Commissioner of the Department of Commerce and Insurance for an independent review of the disputed claims as set forth in T.C.A. 56-32-126. The Independent Review Process is available to Providers to resolve episodes of care disputes. It is understood that in the event Providers file a request with the Commissioner for independent review the dispute, shall be governed by T.C.A. 56-32-126(b).

The request to the Commissioner for Independent Review of Disputed [redacted] Claim form and instructions for completing the form, sample copies of requests to the commissioner for independent review, and FAQ developed by the State of Tennessee Department of Commerce and Insurance can be obtained on the State website (tn.gov/commerce>Our Divisions>[redacted] Oversight>MCO Dispute Resolution>Independent Review Process).

Section IX - Program Changes

[redacted] will review program components as defined by [redacted] and update them as necessary. [redacted] will modify or amend the Program as determined by [redacted] with 30-days' written notice to the Provider.

Section X - Cooperation and Review

Provider, on behalf of itself and/or its Quarterbacks, agrees to cooperate with [redacted] in all ways which affect TennCare's Payment Reform Initiatives. Provider shall be responsible for promptly reviewing all reports provided to

Quarterbacks by [redacted] hereunder. Provider and/or Quarterbacks shall, within 30 days of receipt of such reports, notify [redacted] in writing of any discrepancies or inaccuracies in such reports.

Section XI – Business Associate Agreement

In the event Provider is not a "covered entity", as such term is defined in the HIPAA Regulations; a Business Associate Agreement shall be executed and made a part thereof. Provider acknowledges that if it is not a covered entity, [redacted] is unable to disclose to Provider any protected health information regarding any Covered Person until a Business Associate Agreement is fully effective between the parties hereto.

[redacted] PROVIDER EPISODE-BASED RETROSPECTIVE PAYMENT: THRESHOLDS 2024 Waves 1-9 ATTACHMENT

[redacted] Provider Episode-Based Retrospective Payment: 2024 Thresholds Waves 1-9							
Episodes		Threshold for Quality Indicators Linked to Gain Sharing		Acceptable Threshold	Commendable Threshold	Gain Share Limits	Effective Date
WAVE 1	Asthma	1. Follow-up care within the post-trigger window	30%	$1,216	$756	$196	Jan 2024
		2. Appropriate medications within the trigger and post-trigger window	60%				
	Perinatal	1. Primary C-section	25%[2]	$8,420	$6,368	$2,348	Jan 2024
		2. Hepatitis C screening rate	50%[2]				
		3. HIV screening rate	90%				
	Total Joint Replacement	Related admission during the post-trigger window	10%	$13,561	$9,516	$8,473	Jan 2024
WAVE 2	COPD Acute Exacerbation	Follow-up care within the post-trigger window	45%	$3,288	$1,325	$252	Jan 2024
	Colonoscopy	No quality metrics linked to gain sharing		$1,487	$675	$267	Jan 2024
	Cholecystectomy	Hospital admission in the post-trigger window	10%	$6,665	$3,774	$1,653	Jan 2024
	Acute PCI	Hospital admission in the post-trigger window	10%	$26,000	$6,098	$4,517	Jan 2024
	Non-acute PCI	Hospital admission in the post-trigger window	NA	NA	NA	NA	Jan 2024
WAVE 3	GI Hemorrhage (GIH)	Follow-up care within the post-trigger window	45%	$7,305	$3,680	$376	Jan 2024
	Upper GI endoscopy (EGD)	ED visit within the post-trigger window	10%	$1,685	$822	$368	Jan 2024
	Respiratory Infection	ED visit within the post-trigger window	10%	$221	$105	$21	Jan 2024

	Pneumonia	Follow-up care within the post-trigger window	30%	$2,355	$1,191	$329	Jan 2024
	Urinary Tract Infection (UTI)-Outpatient	1. Admission within the trigger window for ED triggered episodes	5%	$166	$106	$28	Jan 2024
		2. Admission within the trigger window for non-ED triggered episodes	5%				
	Urinary Tract Infection (UTI) Inpatient	Follow-up care within the post-trigger window	40%	$9,818	$4,479	$742	Jan 2024
WAVE 4	Attention Deficit and Hyperactivity Disorder (ADHD)	Minimum Care requirement of 5 visits/claims during the episode window	70%	$625	$268	$65	Jan 2024
		Utilization of therapy for members aged 4 and 5	1 Visit				
	Bariatric Surgery	Follow-up care within the post-trigger window	30%	$9,332	$7,284	$3,815	Jan 2024
	Coronary Artery Bypass Graft (CABG)	Follow-up care within the post-trigger window	NA	NA	NA	NA	Jan 2024
	Congestive Heart Failure (CHF) Acute Exacerbation	Follow-up care within the post-trigger window	60%	$9,792	$4,300	$509	Jan 2024
	Oppositional Defiant Disorder (ODD)	Minimum Care requirement of 6 therapy or level 1 case management visit during the episode window	30%	$1,844	$408	$370	Jan 2024
	Valve repair and replacement	Follow-up care within the post-trigger window	NA	NA	NA	NA	Jan 2024
WAVE 5	Breast Biopsy	Appropriate diagnostic workup rate	90%	$2,877	$1,170	$639	Jan 2024
		Core needle biopsy rate	85%				
	Otitis media	OME episodes without antibiotics filled	25%	$219	$126	$26	Jan 2024
		Non-OME episode with amoxicillin filled	60%				

	Tonsillectomy	Bleeding up to two days following the procedure	5%	$3,791	$2,406	$1,129	Jan 2024
WAVE 6	SSTI	Bacterial cultures when I&D performed-higher is better	50%	$413	$159	$26	Jan 2024
		SSTI episodes with a first line antibiotic	90%[1]				
	HIV	Periodic ART refill	NA	NA	NA	NA	Jan 2024
	Pancreatitis	Follow-up care within the first 30 days of the post-trigger window	35%	$9,749	$5,159	$2,098	Jan 2024
	Diabetes Acute Exacerbation	Follow-up care within the first 30 days of the post trigger window	30%	$7,365	$4,984	$1,151	Jan 2024

[redacted] Provider Episode-Based Retrospective Payment: 2024 Thresholds Waves 1-9

Episodes		Threshold for Quality Indicators Linked to Gain Sharing		Acceptable Threshold	Commendable Threshold	Gain Share Limits	Effective Date
Wave 7	Back/ Neck Pain	Difference in Average MED/day	80%[1]	$600	$251	$39	Jan 2024
	Femur/ Pelvic Fracture	1. Follow-up care within the post-trigger window	NA	NA	NA	NA	Jan 2024
		2. Difference in Average MED/day	NA				
	Knee Arthroscopy	Difference in Average MED/day	80%[1]	$4,816	$3,477	$1,655	Jan 2024
	Non-operative Ankle Injury	Difference in Average MED/day	80%[1]	$400	$235	$50	Jan 2024
	Non-operative Knee Injury	Difference in Average MED/day	80%[1]	$609	$175	$42	Jan 2024
	Non-operative Shoulder Injury	Difference in Average MED/day	80%[1]	$483	$255	$53	Jan 2024
	Non-operative Wrist Injury	Difference in Average MED/day	80%[1]	$522	$227	$45	Jan 2024

	Spinal Decompression	Difference in Average MED/day	80%[1]	$10,250	$5,765	$5,013	Jan 2024
	Spinal Fusion	Difference in Average MED/day	80%[1]	$38,238	$13,522	$9,765	Jan 2024
Wave 8	Acute Gastroenteritis	Abdominal or pelvic CT or MRI in adults	40%	$996	$584	$68	Jan 2024
		Abdominal or pelvic CT or MRI in children	30%				
		Antibiotics utilization	30%				
	Acute Seizure	1. Brain MRI utilization in focal epilepsy	10%	$2,185	$1,003	$207	Jan 2024
		2. Prolonged EEG monitoring utilization in newly diagnosed seizure	10%				
	Appendectomy	1. Abdominopelvic CT scans in children	50%	$7,271	$5,200	$1,395	Jan 2024
		2. Difference in Average MED/day	80%[1]				
	Bronchiolitis	1. Related admission during the post-trigger window	10%	$1,102	$701	$145	Jan 2024
		2. Utilization of bronchodilators	30%				
		3. Utilization of steroids	50%				

[redacted] Provider Episode-Based Retrospective Payment: 2024 Thresholds Waves 1-9							
Episodes		Threshold for Quality Indicators Linked to Gain Sharing		Acceptable Threshold	Commendable Threshold	Gain Share Limits	Effective Date
Wave 8	Colposcopy	1. LEEP utilization under 26 years old with no evidence of high-grade dysplasia	5%[1]	$669	$399	$82	Jan 2024
		2. LEEP utilization with low-grade dysplasia	5%[1]				
	GI Obstruction	Related follow-up care	25%[1]	$20,670	$1,756	$1,527	Jan 2024
		Difference in Average MED/day	80%[1]				
	Hernia Repair	Difference in Average MED/day	80%[1]	$5,587	$3,201	$1,558	Jan 2024
	Hysterectomy	1. Alternative treatments	20%	$8,232	$7,289	$4,266	Jan 2024
		2. Related follow-up care	10%				
	Pediatric Pneumonia	1. Related admission during the post-trigger window	10%	$1,353	$743	$173	Jan 2024

		2. Utilization of macrolides in patients under 6 years old	30%				
		3. Utilization of narrow spectrum antibiotics	50%				
	Syncope	Carotid ultrasound imaging in adult	10%	$858	$224	$38	Jan 2024

[redacted] Provider Episode-Based Retrospective Payment: 2024 Thresholds Waves 1-9							
Episodes		Threshold for Quality Indicators Linked to Gain Sharing		Acceptable Threshold	Commendable Threshold	Gain Share Limits	Effective Date
Wave 9	Cystourethroscopy	1. Difference in average MED/day	80%[1]	$2,112	$962	$129	Jan 2024
		2. Related ED visit within the post-trigger window	10%				
		3. Repeat Cystourethroscopy	5%				
	Acute Kidney and Ureter Stones	1. Difference in average MED/day	80%[1]	$1,371	$617	$284	Jan 2024
		2. Related ED visit within the post-trigger window	15%				

[1] Change in quality metric threshold from 2023 CY.
[2] New gain-sharing quality metric and threshold for 2024 CY.

Acceptable Cost Threshold: The dollar amount, as determined by [redacted] to which the PAP's or QB's risk adjusted average episode cost (calculated in Section II below) for a Program Episode will be compared. The Acceptable Cost Threshold is used to determine the dollar amount of the Shared Risk Payment from the QB to [redacted] and can be found on each interim and final Performance Report provided to the QB.

Commendable Cost Threshold: The dollar amount, as determined by [redacted] to which the QB's average episode cost for a Program Episode will be compared. If the QB meets all of the quality indicators linked to gain sharing, the commendable cost threshold is then used to the determine dollar amount of a shared risk payment from [redacted] to the QB, subject to the Gain Share Limit. The dollar amount of the commendable cost threshold can be found on each interim and final Performance Report provided to the QB.

Additional episodes will be identified as determined by [redacted] and added to this attachment prior to the beginning of each performance period.

INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICF/IID) SERVICES PARTICIPATION ATTACHMENT TO THE [redacted] PROVIDER AGREEMENT

This is an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) Services Participation Attachment ("Attachment") to the [redacted] Provider Agreement ("Agreement"), entered into by and between [redacted] and Provider and is incorporated into the Agreement.

ARTICLE I
OBLIGATIONS OF THE PARTIES

NOW, THEREFORE, for good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree as follows.

1.1 Clean Claim. "Clean Claim" means a request for payment for a service rendered by Provider that (a) is timely submitted by Provider; (b) is accurate; (c) is submitted on a HIPAA compliant standard claim form including a CMS 1500 (08-05) or UB-04 CMS 1450 or successor forms thereto or the electronic equivalent of such claim form; (d) is a complete claims submission following any and all HIPAA compliance standards (Levels1-7); (e) includes National Provider Identifier and Taxonomy information for Rendering, Attending and Billing providers; (f) includes, for all J-codes billed, NDC code and drug pricing information (NDC quantity, unit price and unit of measurement) are required, exceptions are: vaccines for children which are paid as an administrative fee, inpatient administered drugs, radiopharmaceuticals unless the drug is billed separately from the procedure; and that requires no further information, adjustment, or alteration by Provider in order to be processed and paid by [redacted] A Claim is "timely submitted" under this Agreement if it is submitted within the timeframes required by this Agreement. A Clean Claim includes resubmitted Claims with previously identified deficiencies corrected and is resubmitted within the timeframes required by this Agreement.

1.2 Adult and Children Protective Services. Provider agrees to report suspected abuse, neglect, and exploitation of adults in accordance with TCA 71-6-103 to the Tennessee Department of Human Services and to report suspected brutality, abuse, or neglect of children in accordance with TCA 37-1-403 and TCA 37-1-605 to the Tennessee Department of Children's Services.

1.3 Member Care Coordinator Notification. Provider shall notify a Member's care coordinator of any significant changes in the Member's needs or care, hospitalizations, emergency room visits or recommendations for additional Medicaid Covered Services. [redacted] will notify the Provider in writing of all assigned care coordinators for each Member in their facility.

1.4 Notification to [redacted] Hospitals, including psychiatric hospitals shall cooperate pursuant to CRA Sections 2.9.6.7 and 2.9.6.8 with [redacted] in developing and implementing protocols as part of [redacted] facility diversion plan which shall include, at a minimum, the hospital's obligation to promptly notify [redacted] upon admission of an eligible Member regardless of payor source for the hospitalization; how the hospital will identify Members who may need home health, private duty nursing, nursing facility, or Home and Community Based Services ("HCBS") upon discharge, and how the hospital will engage [redacted] in the discharge planning process to ensure that Members receive the most appropriate and cost-effective medically necessary services upon discharge.

1.5 Reportable Event Management (REM).

1.5.1 Provider shall report, respond to, and document for three (3) categories of reportable events: Tier 1, Tier 2, and Additional Reportable Events and Interventions, as outlined by the State Agency and the Department of Intellectual and Developmental Disabilities (DIDD) in the REM protocol, and as defined in the [redacted] I/DD MLTSS Supplemental Provider Manual in accordance with applicable requirements as outlined within the Government Contract and per federal reporting for ICF/IID.

1.5.1.1 [redacted] shall implement the REM reporting process as directed by the State Agency, to include the Reportable Event Form (REF) issued for reporting reportable events and reporting timeframes. All Tier 1 Reportable Events must be verbally reported to the DIDD Abuse Hotline as soon as possible, but no later than four (4) hours after the occurrence of the event or the discovery. The provider shall submit a corresponding REF for Tier 1 Reportable Events within one (1) business day of the Hotline report. [redacted] shall also

require that such providers provide initial notification to [redacted] using the REF for all Tier 2 Reportable Events within one (1) business day from the date of witnessing or discovering the Tier 2 Reportable Event.

1.5.1.2 Provider shall ensure that its staff and contract providers immediately take effective steps to prevent further harm to any and all Members and respond to any emergency needs of Members.

1.5.1.3 Provider with a reportable event shall conduct an internal reportable event investigation for a Tier 2 Reportable Events and submit a report on the investigation within the timeframe specified by [redacted] The timeframe for submitting the completed investigation report shall be as soon as possible, may be based on the severity of the event, and, except under extenuating circumstances, shall be no more than twenty-five (25) calendar days after the anchor date of the event. [redacted] shall review the Provider's report and follow-up with the Provider as prescribed by the REM protocol.

1.5.1.4 Provider shall cooperate with any investigation conducted by [redacted] or outside agencies (e.g., State Agency, Adult Protective Services (APS), Child Protective Services (CPS), and law enforcement).

1.5.1.5 Provider shall provide appropriate training and taking corrective action as needed to ensure its staff, contract providers, the FEA, and workers comply with reportable event requirements.

1.5.1.6 Provider shall conduct oversight, including but not limited to oversight of its staff, contracted providers, and the FEA, to ensure that [redacted] policies and procedures are being followed and that necessary follow-up is being conducted in a timely manner.

1.6 Criminal Background Checks. In accordance with applicable Regulatory Requirements, Provider shall perform criminal background checks for all employed or contracted individuals providing Medicaid Covered Services under this Agreement.

1.7 Transfers and Discharges. Intermediate Care Facilities treating Members with Intellectual Disabilities and participating in the Medicaid Program must comply with the following guidelines regarding transfers, discharges and/or readmissions.

1.7.1 Promptly notify [redacted] of a Member's request for admission into and prior to discharge;

1.7.2 Admit only those Members who have completed a Community Informed Choice process and have been approved by the State for admission;

1.7.3 Provide written notification to State Agency and [redacted] in accordance with state and federal requirements before voluntarily terminating this Agreement, and to comply with all applicable state and federal requirements regarding voluntary termination;

1.7.4 Prior to an involuntary discharge:

1.7.4.1 Notify [redacted]

1.7.4.2 Consult with the Member;

1.7.4.3 Prepare and implement a discharge and/or transition plan while providing sufficient time to prepare the Member and his/her parents or guardian for the discharge or transfer.

1.7.5 Prior to voluntary discharge Provider must:

1.7.5.1 Notify [redacted] and the Member and/or Member's representative in writing prior to a voluntary discharge, in accordance with state and federal requirements including involving the Member and his/her family or legal guardian in palling for any transfer to discharge.

1.7.5.2 Develop a final summary that includes the following:

1.7.5.2.1 A summary of the Member's developmental behavioral, social, and nutritional status;

1.7.5.2.2 Current status of the objectives listed in the Member's IPP;

1.7.5.2.3 Post-discharge plan of care;

1.7.6 Provider must assist in the certification and recertification of Member's level of care eligibility for ICF/IID services and level of need for and receipt of continuous active treatment. Provider must cooperate fully with [redacted] in the completion and submission of the level of care assessment.

1.7.7 Provider must submit complete and accurate PAEs and include all required documentation.

1.7.8 Notify [redacted] of any change in the Member's medical or functional condition that could impact the Member's level of care eligibility and level of need or and receipt of continuous active treatment.

1.7.9 Provider must comply with state and federal laws and regulations applicable to ICFs/IID, including the Americans with Disabilities Act and those that govern admission, transfer and discharge policies.

1.8 Transfer and Discharge Rights. An Intermediate Care Facility must permit each resident to remain in the facility and must not transfer or discharge the resident from the facility unless;

1.8.1 The transfer or discharge is necessary to meet the resident's welfare which cannot be met in the facility;

1.8.2 The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;

1.8.3 The safety of individuals in the facility is endangered;

1.8.4 The health of individuals in the facility would otherwise be endangered;

1.8.5 The resident has failed, after reasonable and appropriate notice, to pay (or to have paid under Title XIX or Title XVIII on the resident's behalf) for a stay at the facility; or

1.8.6 The facility ceases to operate.

1.8.7 In each of the cases described above, no patient shall be discharged or transferred without a written order from the attending physician or through other legal processes and timely notification of next of kin and/or sponsor or authorized representative, if any. Each Facility shall establish a policy for handling patients who wish to leave the facility against medical advice. The basis for the transfer or discharge must be documented in the resident's clinical record. In the cases described in the clauses 1.8.1. and 1.8.2, the documentation must be made by the resident's physician, and in the case described in clause 1.8.4 the documentation must be made by a physician. For purposes of clause 1.8.5, in the case of a resident who becomes eligible for assistance under Title XIX after admission to the facility, only charges which may be imposed under Title XIX shall be considered to be allowable. When a patient is transferred, a summary of treatment given at the facility, condition of patient at time of transfer and date and place to which transferred shall be entered in the record. If transfer is due to an emergency; this information will be recorded within forty-eight (48) hours; otherwise, it will precede the transfer of the patient. When a patient is transferred, a copy of the clinical summary should, with consent of the patient, be sent to the Intermediate Care Facility that will continue the care of the patient. Where an involuntary transfer is proposed, in addition to any other relevant factors, the following factors shall be taken into account:

1.8.7.1 The traumatic effect on the patient.

1.8.7.2 The proximity of the proposed Intermediate Care Facility to the present facility and to the family and friends of the patient.

1.8.7.3 The availability of necessary medical and social services at the proposed Intermediate Care Facility.

1.8.7.4 Compliance by the proposed Intermediate Care Facility with all applicable Federal and State regulations.

1.9 Pre-Transfer and Pre-Discharge Notice. Before effective a transfer or discharge of a resident, Provider must:

1.9.1 Notify- [redacted] and the resident (and, if known, a family member of the resident or legal representative) of the transfer or discharge and the reasons therefore.

1.9.2 Record the reasons in the resident's clinical record (including any documentation required pursuant to 1.8 above) and include in the notice the items described in 1.11 below.

1.9.3 Notify the Department.

1.9.4 Not transfer or discharge a resident until the above agencies have designated their intention to intervene and until any appeal process is complete, should the resident request a fair hearing.

1.10 Timing of Notice. The notice under 1.9 must be made at least thirty (30) days in advance of the resident's transfer or discharge except:

1.10.1 In a case described in 1.8.3 above.

1.10.2 In a case described in 1.8.2 where the resident's health improves sufficiently to allow a more immediate transfer or discharge.

1.10.3 In a case described in 1.8.1 where a more immediate transfer or discharge is necessitated by the resident's urgent medical needs.

1.10.4 In a case where a resident has not resided in the facility for thirty (30) days. In the case of such exceptions, notice must be given as many days before the date of transfer or discharge as is practicable.

1.11 Items Included in Notice. Each pre-transfer and pre-discharge notice under 1.9 must include:

1.11.1 Information on the Member's right to appeal the transfer or discharge;

1.11.2 In the case of residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy system for developmentally disabled individuals.

1.11.3 In the case of mentally ill residents, the mailing address and telephone number of the agency responsible for the protection and advocacy system for mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.

1.12 Orientation. Provider must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer OT discharge from the facility.

1.13 Notice of Bed-Hold Policy and Readmission. Before a resident of Facility is transferred for hospitalization or therapeutic leave, Provider must provide written information to [redacted] the resident, and a family member or legal representative concerning:

1.13.1 The provisions of the State plan under this Title XIX regarding the period (if any) during which the resident will be permitted under the State plan to return and resume residence in the facility, and

1.13.2 The policies of the facility consistent with 1.14 below, regarding such a period.

1.14 Notice Upon Transfer. At the time of transfer of a resident to a hospital or for therapeutic leave, Provider must provide written notice to the resident and a family member or legal representative of the duration of any period under the State plan allowed for the resumption of residence in the facility.

1.15 Provider must cooperate with [redacted] in developing and implementing protocols as part of the diversion and transition plan in accordance with all applicable laws.

1.16 Monitoring. [redacted] may monitor the quality of services delivered by Provider hereunder and may initiate corrective action when necessary to improve quality of care in accordance with that level of medical or behavioral health, or long-term care which is recognized as acceptable professional practice in the respective community in which Provider practices and/or the standards established by applicable State Agency. Provider shall comply with corrective action plans initiated by [redacted] Provider acknowledges that [redacted] has the right to monitor Covered Services furnished by Provider to Members in accordance with policies and procedures of [redacted] that are made known to Provider, and that such monitoring may be announced or unannounced. Provider shall comply with all applicable quality requirements to which [redacted] must comply as required by applicable State Agency.

1.17 Cost Sharing Requirements. Provider shall collect appropriate patient liability amounts from Members, notifying the Member's care coordinator if there is an issue with collecting Member's patient liability, and the provider must demonstrate and document a good faith effort in collecting patient liability amounts.

1.18 CRG/TPG Assessments. Pursuant to this Agreement, if Provider furnishes Clinically Related Group (CRG) and Target Population Group (TPG) assessments, Provider is responsible for ensuring that all CRG/TRG assessments are completed by State-certified raters and that the assessments are completed within fourteen (14) days of a request. The rater certification process shall include completing the CRG/TPG assessments training and passing the State rater competency examination scored only by State-certified trainers. [redacted] will conduct audits of any CRG/TPG assessments for accuracy and conformity to state policies and procedures. [redacted] shall audit the Provider's conduct of these assessments on at least an annual basis. The methodology for these audits and the results of these audits will be reported as required by [redacted] to the applicable State Agency.

1.19 Additional Government Contract Requirements. Providers agree to:

1.19.1 Promptly notify [redacted] and/or State entity as directed by the applicable State Agency, of a Member's admission or request for admission to the Facility regardless of payor source for the facility stay, or when there is a change in a Member's known circumstances and to notify [redacted] prior to a Member's discharge;

1.19.2 Ensure, as a condition of payment for services, that there is a timely certification and recertification (as applicable) of the Member's level of care eligibility for Intermediate Care Facility services, to cooperate fully with [redacted] in the completion and submission of the level of care assessment, and to notify [redacted] of any change in the Member's medical or functional condition which could impact the Member's level of care eligibility for the currently authorized level of Intermediate Care Facility services;

1.19.3 Comply with state and federal laws and regulations applicable to Intermediate Care Facilities as well as any applicable federal court orders, including but not limited to those which govern admission, transfer, and discharge policies;

1.19.4 Comply with federal Pre-Admission Screening and Resident Review (PASRR) requirements applicable to all Facility residents, regardless of payor source, including that a level I screening be completed prior to admission, a level II screening be completed when indicated by the level I screening, and a review be completed based upon a significant physical or mental change in the resident's condition which might impact the Member's need for or benefit from specialized services; the facility shall collaborate with [redacted] and with other Providers as needed to help ensure that current information regarding the Member's mental health or intellectual disabilities needs (as available) is reflected in the PASRR screening in order to support an appropriate PASRR determination;

1.19.5 Have on file a system designed and utilized to insure the integrity of the Member's personal financial resources. This system shall be designed in accordance with the regulations and guidelines set out by the Comptroller of the Treasury and the applicable federal regulations;

1.19.6 Immediately notify [redacted] of any change in its license to operate as issued by the Tennessee Department of Health as well as any deficiencies cited during the federal certification process;

1.19.7 That if the Intermediate Care Facility provider is involuntarily decertified by the Tennessee Department of Health or the Centers for Medicare and Medicaid Services, the provider agreement will automatically be terminated.

1.19.8 That the provider agreement shall be assignable from [redacted] to the State, or its designee, at the State's discretion upon written notice to [redacted] and the affected Intermediate Care Facility provider. Further, the provider agreement shall include language by which the Intermediate Care Facility provider agrees to be bound by any such assignment, and that the State, or its designee, shall not be responsible for past obligations of [redacted]

1.19.9 Require the Intermediate Care Facility to provide advance written notice to [redacted] and the applicable State Agency before voluntarily terminating the agreement and specify the timeframe for providing such notice.

1.19.10 Require the Intermediate Care Facility provider to notify [redacted] immediately if the Intermediate Care Facility is considering discharging a Member and to consult with the Member's care coordinator to intervene in resolving issues if possible and, if not, to prepare and implement a discharge and/or transition plan as appropriate.

1.19.11 Require the Intermediate Care Facility to notify the Member and /or the Member's representative (if applicable) in writing prior to discharge in accordance with state and federal requirements.

1.19.12 Require the Provider to coordinate with [redacted] in complying with the requirements in 42 CFR 483.75 regarding written transfer agreements and shall use contract providers when transfer is medically appropriate, except as authorized by [redacted] or for emergency services.

1.19.13 Develop protocols and processes to work with facilities to coordinate the provision of care. At minimum, a care coordinator assigned to a resident to the Facility shall participate in Grand Rounds quarterly, at least two of which shall be conducted onsite in the facility, and the Grand Rounds shall identify and address any Member who has experienced a potential significant change in needs or circumstances or about whom the Provider has expressed concerns.

1.19.14 Develop and implement with [redacted] targeted strategies to improve health, functional, or quality of life outcomes, e.g., related to disease management or pharmacy management, or to increase and/or maintain functional abilities.

1.19.15 Coordinate with [redacted] as necessary to facilitate access to physical health and/or behavioral health services needed by the Member to help ensure the proper management of the Member's acute and/or chronic health conditions including services covered by [redacted] that are beyond the scope of the Provider services benefit. At a minimum, the Provider shall consider the following a potential significant change in needs or circumstances for Members who are residing in a facility:

1.19.15.1 Pattern of recurring falls

1.19.15.2 Incident injury or complaint

1.19.15.3 Report of abuse or neglect

1.19.15.4 Frequent hospitalizations, or

1.19.15.5 Prolonged or significant change in health and/or functional status.

1.19.16 Require Facility to screen their employees and contractors initially and on an ongoing monthly basis to determine whether any of them has been excluded from participation in Medicare, Medicaid, SCHIP, or any Federal health care programs (as defined in Section 1128B(f) of the Social Security Act) and not employ or contract with an individual or entity that has been excluded. The Facility shall be required to immediately report to [redacted] any exclusion information discovered. The Facility shall be informed that civil monetary penalties may be imposed against Providers who employ or

enter into contracts with excluded individuals or entities to provide items or services to Covered Person's.

1.19.17 The Facility shall accept payment or appropriate denial made by [redacted] (or, if applicable, payment by [redacted] that is supplementary to the Member's third party payer) plus the amount of any applicable patient liability, as payment in full for Medicaid Covered Services provided and shall not solicit or accept any surety or guarantee of payment from the Member in excess of the amount of applicable patient liability responsibilities. Member shall include the patient, parent(s), guardian, spouse or any other legally responsible person of the Member being served

1.19.18 When there is a change of ownership of Facility, the new legal entity shall provide to the applicable State Agency a bill of sale (or equivalent) and documentation from the appropriate State licensing entity stating that the new legal entity is allowed to operate under the existing license until such time as a new license is issued. The applicable State Agency shall issue a new Medicaid ID based on this provider-submitted documentation, and [redacted] shall enter into a provider agreement with the new provider prior to the effective date of the change of ownership. A new provider with a Medicaid ID and a provider agreement with [redacted] which shall include, but not be limited to, the assumption of the previous owner's agreement, a new agreement with [redacted] or a single case agreement, shall be reimbursed at one hundred percent (100%) from the effective date of the change of ownership. A new provider with a change of ownership that has not acquired a Medicaid ID shall not be reimbursed, including retroactively, until such provider acquires a Medicaid ID.

1.19.19 In the event the contract is terminated because of a change of ownership, [redacted] shall remain obligated to pay for reimbursable services rendered prior to termination of the contract and that become due after the contract is terminated subject to timely filing requirements.

1.20 The Provider shall submit complete and accurate PAEs that satisfy all technical requirements specified by the applicable State Agency, and accurately reflect the Member's current medical and functional status, including Safety Determination Requests. The Provider shall also submit all supporting documentation required in the PAE and Safety Determination Request Form, as applicable and required pursuant to the applicable State Agency Rules.

1.21 Non-Discrimination. Provider shall abide by the federal Civil Rights Act of 1964, the Federal Rehabilitation Act of 1973, and all other applicable statutes, regulations and orders (including, without limitation, Executive Orders 11246 and 11375, "Equal Employment Opportunities") as amended, and any and all successor statutes, regulations and related orders. Provider shall not exclude any Medicaid Member from participation in any aid, care, service or other benefit, or deny any Medicaid Member such Medicaid Covered Services on the grounds of handicap, and/or disability, age, race, color, religion, sex, national origin or any other classifications protected under federal or state laws, or be denied benefits of, or be otherwise subjected to discrimination in the performance of Provider's obligation under its agreement with [redacted] or in the employment practices of the Provider. Provider will cooperate with the applicable State Agency and/or CMS, and [redacted] as applicable, during discrimination complaint investigations. The Provider will assist any Medicaid Member in obtaining discrimination complaint forms and contact information for [redacted] Nondiscrimination Office. Provider shall upon request show proof of such nondiscrimination compliance and shall post notices of nondiscrimination in conspicuous places available to all employees, the applicable State Agency applicants, and Covered Person's.

[redacted] MEDICAID/COVERKIDS
PARTICIPATION ATTACHMENT TO THE
[redacted] PROVIDER AGREEMENT

This is a [redacted] Medicaid/CoverKids Participation Attachment ("Attachment") to the [redacted] Provider Agreement ("Agreement"), entered into by and between [redacted] and Provider and is incorporated into the Agreement.

ARTICLE I
DEFINITIONS

The following definitions shall apply to this Attachment. Terms not otherwise defined in this Attachment shall carry the meaning set forth in the Agreement.

All references to "[redacted] under this Medicaid Participation Attachment shall mean and refer to [redacted] Tennessee, Inc.

"Audit" means a review or audit of any and all obligations, requirements, records and information set forth in this Participation Attachment by the entities named herein.

"Clean Claim" means, unless otherwise required by applicable state Regulatory Requirements, an accurate and timely filed Claim submitted pursuant to this Attachment, that has no defect or impropriety, for which all information necessary to process such Claim and make a benefit determination is included. This includes but is not limited to, the claim being submitted in a nationally accepted format in compliance with standard coding guidelines, and which does not require adjustment, or alteration by Provider of the services in order to be processed and paid.

"Cloning of Medical Notes" means documentation is considered cloned when each entry in the medical record for a beneficiary is worded exactly like or similar to the previous entries. Cloned documentation does not meet Medical Necessity requirements for coverage of services rendered due to the lack of specific, individual information. All documentation in the medical record must be specific to the patient and her/his situation at the time of the encounter. Cloning of documentation is considered a misrepresentation of the Medical Necessity requirement for coverage of services. Identification of this type of documentation will lead to denial of services for lack of Medical Necessity and recoupment of all overpayments made.

"CoverKids" includes children under age 19 and Mothers of unborn eligible who do not qualify for [redacted] but meet the condition of the State Child Health Plan under Title XXI of the Social Security Act State Children's Health Insurance Program.

"Eligible" means, for purposes of this Attachment, any person certified by [redacted] as eligible to receive services and benefits under the [redacted] program or the CoverKids program.

"Ethical and Religious Directives (ERDs)" means a document that offers moral guidance on various aspects of health care delivery and is based on a religious organization's theological and moral teachings.

"Medicaid Covered Services" means, for purposes of this Attachment, only those Covered Services provided under [redacted] Medicaid Program(s), i.e., the package of health care services, including physical health, behavioral health, and long-term care services, that define the covered services available to [redacted] members.

"Medicaid Member" means, for purposes of this Attachment, a Member who is enrolled in [redacted] Medicaid Program(s) under [redacted] For all purposes related to this Attachment, including all schedules, exhibits, provider manual(s), notices and communications related to this Attachment, the term "Medicaid Member" may be used interchangeably with the terms [redacted] Standard Enrollee, [redacted] Medicaid Enrollee, and the meaning of each is synonymous with any such other unless otherwise stated in this Attachment.

"Medicaid Program(s)" means, for purposes of this Attachment, a medical assistance program provided under a Health Benefit Plan approved under Title XVI, Title XIX and/or Title XXI of the Social Security Act or any other federal or state funded program or product as designated by [redacted]

"Medically Necessary/Medical Necessity" means:

A. Those services that are recommended by a physician or other licensed healthcare provider practicing within the scope of the physician's license who is treating the Medicaid Member. A Medically Necessary Medicaid Covered Service must satisfy each of the following criteria:

(i) It must be required in order to diagnose or treat a Medicaid Member's medical condition. The convenience of a Medicaid Member, a Medicaid Member's family, or a provider shall not be a factor or justification in determining that a medical item or service is Medically Necessary;

(ii) It must be safe and effective. To qualify as safe and effective, the type and level of medical item or service must be consistent with the symptoms or diagnosis and treatment of the particular medical condition, and the reasonably anticipated medical benefits of the item or service must outweigh the reasonably anticipated medical risks based on the Medicaid Member's condition and scientifically supported evidence;

(iii) It must be the least costly alternative course of diagnosis or treatment that is adequate for the medical condition of the Medicaid Member. When applied to medical items or services delivered in an inpatient setting, it further means that the medical item or service cannot be safely provided for the same or lesser cost to the person in an outpatient setting. Where there are less costly alternative courses of diagnosis or treatment, including less costly alternative settings that are adequate for the medical condition of the Medicaid Member, more costly alternative courses of diagnosis or treatment are not Medically Necessary. An alternative course of diagnosis or treatment may include observation, lifestyle or behavioral changes or, where appropriate, no treatment at all; and

(iv) It must not be experimental or investigational. A medical item or service is experimental or investigational if there is inadequate empirically-based objective clinical scientific evidence of its safety and effectiveness for the particular use in question. This standard is not satisfied by a provider's subjective clinical judgment on the safety and effectiveness of a medical item or service or by a reasonable medical or clinical hypothesis based on an extrapolation from use in another setting or from use in diagnosing or treating another condition such as:

(a) Use of a drug or biological product that has not been approved under a new drug application for marketing by the United States Food and Drug Administration (FDA) and is deemed experimental; or

(b) Use of a drug or biological product that has been approved for marketing by the FDA but is proposed to be used for other than the FDA-approved purpose. It will not be deemed Medically Necessary unless the use can be shown to be widespread, to be generally accepted by the professional medical community as an effective and proven treatment in the setting and for the condition for which it is used, and to satisfy the requirements of subdivisions (A)(i) – (A)(iii).

B. It is the responsibility of the Medicaid Program ultimately to determine what medical items and services are Medically Necessary for the Medicaid Program. The fact that a provider has prescribed, recommended or approved a medical item or service does not, in itself, make such item or service Medically Necessary. Medical Necessity and Medically Necessary as used in the Agreement shall have the meaning contained in Tenn. Code Ann. 71-5-144, [redacted] Rule 1200-13-16, and other [redacted] rules, as applicable. In the case of enrollees under 21 years of age, services shall be provided in accordance with EPSDT requirements including federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989.

"State Agency," if used, means a federal, state or local agency, administration, board or other governing body with jurisdiction over the governance or administration of a Medicaid Program.

"Subcontract" means a contract to perform or assist, even if incidentally or in an auxiliary capacity, in the performance of all or part of the Provider's duties or obligations under the Agreement and/or this Attachment. An agreement entered into by the Provider with any other organization or person who agrees to perform any administrative function or service for the Provider specifically related to securing or fulfilling the Provider's obligations to [redacted] under the terms of this Attachment when the intent of such an agreement is to delegate the responsibility for any major service or group of services required by this Attachment. This shall also include any and all agreements between any and all subcontractors for the purposes related to securing or fulfilling the Provider's obligations to [redacted] under the terms of this Attachment.

"Subcontractor" means an individual, agency, or organization that pursuant to a Subcontract performs or assists, even if incidentally or in an auxiliary capacity, in the performance of all or part of the Provider's duties or obligations under the Agreement and/or this Attachment. Any organization or person who provides any function or service for the Provider specifically related to securing or fulfilling the Provider's obligations to [redacted] under the terms of this Attachment. Subcontractor does not include Provider unless the Provider is responsible for services other than those that could be covered in a Provider Agreement.

"[redacted] or "[redacted] Program" means the program administered by the single state agency, as designated by the state and CMS, pursuant to Title XIX of the Social Security Act and the Section 1115 research and demonstration waiver granted to the State of Tennessee and any successor programs. For purposes of the contract requirements herein, references to [redacted] or the [redacted] Program shall include CoverKids unless otherwise specified.

"[redacted] Kids" means the Early Periodic Screening, Diagnostic and Treatment ("EPSDT") program operated by [redacted] The EPSDT service is Medicaid's comprehensive and preventive child health program for individuals under the age of 21.

"[redacted] Compensation Schedule" ("WCS") means the document(s) attached hereto and incorporated herein by reference, and which sets forth the [redacted] Rate(s) and compensation related terms for the Network(s) in which Provider participates. The WCS may include additional Provider obligations and specific [redacted] compensation related terms and requirements.

ARTICLE II
SERVICES/OBLIGATIONS

2.1 Participation-Medicaid Network. As a participant in [redacted] Medicaid Network, Provider will render Medicaid Covered Services to Medicaid Members in accordance with the terms and conditions of the Agreement and this Attachment. Such Medicaid Covered Services provided shall be within the scope of Provider's licensure, expertise, and usual and customary range of services pursuant to the terms and conditions of the Agreement and this Attachment, and Provider shall be responsible to [redacted] for his/her/its performance hereunder. Except as set forth in this Attachment or the [redacted] Compensation Schedule ("WCS"), all terms and conditions of the Agreement will apply to Provider's participation in [redacted] Medicaid Network. The terms and conditions set forth in this Attachment are limited to the provision of and payment for Health Services provided to Medicaid Members.

2.2 Provider's Duties and Obligations to Medicaid Members. All of Provider's duties and obligations to Members set forth in the Agreement shall also apply to Medicaid Members unless otherwise specifically set forth in this Attachment. Provider shall not discriminate in the acceptance of Medicaid Members for treatment, and shall provide to Medicaid Members the same access to services, including but not limited to, hours of operation, as Provider gives to all other patients. Provider shall furnish [redacted] with at least ninety (90) days prior written notice if Provider plans to close its practice to new patients or ceases to continue in Provider's current practice.

2.2.1 To the extent mandated by Regulatory Requirements, Provider shall ensure that Medicaid Members have access to twenty-four (24) hour-per-day, seven (7) day-per-week urgent and Emergency Services, as defined in the WCS.

2.2.2 Unless otherwise required under Regulatory Requirements, a PCP, as defined in the WCS, shall provide Covered Services or make arrangements for the provision of Covered Services to Medicaid Members on a twenty-four (24) hour-per-day, seven (7) day-per-week basis to assure availability, adequacy, and continuity of care to Medicaid Members. If Provider is unable to provide Covered Services, Provider shall arrange for another Participating Provider to cover Provider's patients in accordance with [redacted] Policies. Provider and any PCPs employed by or under contract with Provider may arrange for Covered Services to Medicaid Members to be performed by a Specialist Physician only in accordance with [redacted] Policies.

2.2.3 If Provider is furnishing Specialist Physician services under this Attachment, Provider and the Specialist Physician(s) employed by or under contract with Provider, shall accept as patients all Medicaid Members and may arrange for Covered Services to Medicaid Members to be performed by Specialist Physician only in accordance with [redacted] Policies.

2.2.4 Provider may not refuse to provide Medically Necessary or covered preventive services to a child under the age of twenty-one (21) or a Medicaid Member under this Attachment for non-medical reasons. However, Provider shall not be required to accept or continue treatment of a patient with whom Provider feels he/she cannot establish and/or maintain a professional relationship.

2.3 Provider Responsibility. [redacted] shall not be liable for, nor will it exercise control or direction over, the manner or method by which Provider provides Health Services to Medicaid Members. Provider shall be solely responsible for all medical advice and services provided by Provider to Medicaid Members. Provider acknowledges and agrees that [redacted] may deny payment for services rendered to a Medicaid Member which it determines are not Medically Necessary, are not Medicaid Covered Services under the applicable Medicaid Program(s), or are not otherwise provided or billed in accordance with the Agreement and/or this Attachment. A denial of payment or any action taken by [redacted] pursuant to a utilization review, referral, discharge planning program or claims adjudication shall not be construed as a waiver of Provider's obligation to provide appropriate Health Services to a Medicaid Member under applicable Regulatory Requirements and any code of professional responsibility. However, this provision does not require Provider to provide Health Services if Provider objects to such service on moral or religious grounds.

2.4 Reporting Fraud and Abuse. Provider shall cooperate with [redacted] anti-fraud compliance program. If Provider identifies any actual or suspected fraud, abuse or misconduct in connection with the services rendered hereunder in violation of Regulatory Requirements, Provider shall immediately report such activity directly to the compliance officer of [redacted] or through the compliance hotline in accordance with the provider manual(s) or to the [redacted] Office of Program Integrity. In addition, Provider is not limited in any respect in reporting other actual or suspected fraud, abuse, or misconduct to [redacted]

2.5 [redacted] Marketing/Information Requirements. Provider agrees to abide by [redacted] marketing/information requirements. Provider shall forward to [redacted] for prior approval all flyers, brochures, letters and pamphlets Provider intends to distribute to [redacted] Members concerning its payor affiliations, or changes in affiliation or relating directly to the [redacted] population. Provider will not distribute any marketing or recipient informing materials without the consent of [redacted] or [redacted] Provider shall not use [redacted] name or trademark for any materials intended for dissemination to Medicaid Members unless said material has been submitted to [redacted] by [redacted] for review and approval. This prohibition shall not include references to whether or not Provider participates in [redacted]

2.6 Schedule of Benefits and Determination of Medicaid Covered Services. [redacted] shall make available upon Provider's request schedules of Medicaid Covered Services for applicable Medicaid Program(s), and will notify Provider in a timely manner of any material amendments or modifications to such schedules. [redacted] will not issue any payments to Provider until Provider has obtained a Tennessee Medicaid provider number and has complied with the disclosure requirements, as applicable, in accordance with 42 CFR 455.100 through 106 and [redacted] policies and procedures.

2.7 Medicaid Member Verification. Provider shall establish a Medicaid Member's eligibility for Medicaid Covered Services prior to rendering services, except in the case of an Emergency Condition, as defined in the WCS, where such verification may not be possible. In the case of an Emergency Condition, Provider shall establish a Medicaid Member's eligibility as soon as reasonably practical. [redacted] provides for member eligibility verification 24/7/365 on its website. Nothing contained in this Attachment or the Agreement shall, or shall be construed to, require advance notice, coverage verification, or pre-authorization for Emergency Services, as defined in the WCS, provided in accordance with the federal Emergency Medical Treatment and Labor Act ("EMTALA") prior to Provider's rendering such Emergency Services.

2.8 Hospital Affiliation and Privileges. To the extent required under [redacted] credentialing requirements, Provider or any Participating Providers employed by or under contract or subcontract with Provider shall maintain privileges to practice at one or more of [redacted] participating hospitals. In addition, in accordance with the Change in Provider Information Section of the Agreement, Provider shall immediately notify [redacted] in the event any such hospital privileges are revoked, limited, surrendered, or suspended at any hospital or healthcare facility.

2.9 Participating Provider Requirements. If Provider is a group provider, Provider shall require that all Participating Providers employed by or under contract or subcontract with Provider comply with all terms and conditions of the Agreement and this Attachment. Notwithstanding the foregoing, Provider acknowledges and agrees that [redacted] is not obligated to accept as Participating Providers all providers employed by or under contract or subcontract with Provider.

2.10 Coordinated and Managed Care. Provider shall participate in utilization management and care management programs designed to facilitate the coordination of services as referenced in the applicable provider manual(s).

2.11 Representations and Warranties. Provider represents and warrants that all information provided to [redacted] is true and correct as of the date such information is furnished, and that Provider is unaware of any undisclosed facts or circumstances that would make such information inaccurate or misleading. Provider further represents and warrants that Provider: (i) is legally authorized to provide the services contemplated hereunder; (ii) is qualified to participate in all applicable Medicaid Program(s); (iii) is not in violation of any licensure or accreditation requirement applicable to Provider under Regulatory Requirements; (iv) has not been convicted of bribery or attempted bribery of any official or employee of the jurisdiction in which Provider operates, nor made an admission of guilt of such conduct which is a matter of record; (v) is capable of providing all data related to the services provided hereunder in a timely manner as reasonably required by [redacted] to satisfy its internal requirements and Regulatory Requirements, including, without limitation, data required under the Healthcare Effectiveness Data and Information Set ("HEDIS") and National Committee for Quality Assurance ("NCQA") requirements; and (vi) is not, to Provider's best knowledge, the subject of an inquiry or investigation that could foreseeably result in Provider failing to comply with the representations set forth herein. In accordance with the Change in Provider Information Section of the Agreement, Provider shall immediately provide [redacted] with written notice of any material changes to such information.

2.11.1 Provider shall conduct criminal background checks registry checks, and exclusions, which shall include a check of the Tennessee Abuse Registry, National and Tennessee Sexual Offender Registry, in accordance with state law and [redacted] policy.

2.12 Third Party Liability. Provider agrees to identify third party liability coverage, including Medicare and long-term care insurance as applicable, and except as otherwise required, seek such third party liability payment before submitting claims to [redacted]

2.13 [redacted] Kids. If Provider furnishes EPSDT services under the [redacted] Kids program, upon request, [redacted] shall make available to Provider a description of the package of benefits that [redacted] Kids offers and require providers to make treatment decisions based upon children's individual medical and behavioral health needs, and make appropriate referrals and document said referrals in the child's medical record. In furnishing such [redacted] Kids services, Provider shall comply with the requirements set forth in the provider manual.

ARTICLE III
COMPENSATION AND AUDIT

3.1 Submission and Adjudication of Medicaid Claims. Unless otherwise instructed, or required by Regulatory Requirements, Provider shall submit Claims to [redacted] using appropriate and current Coded Service Identifier(s), within one hundred twenty (120) days from the date the Health Services are rendered or [redacted] may refuse payment. If [redacted] is the secondary payor, the one hundred twenty (120) day period will not begin until Provider receives notification of primary payor's responsibility.

3.1.1 In situations of enrollment in [redacted] with a retroactive eligibility date, the time frames for filing a claim shall begin on the date that [redacted] receives notification from [redacted] of the Medicaid Member's eligibility/enrollment. Provider agrees to submit Claims in a format consistent with industry standards and acceptable to [redacted] either (a) electronically through electronic data interchange ("EDI"), or (b) if electronic submission is not available, utilizing paper forms as defined by the National Uniform Claim Committee ("NUCC").

3.1.2 Provider agrees to provide to [redacted] unless otherwise instructed, at no cost to [redacted] or the Medicaid Member, all information necessary for [redacted] to determine its payment liability. Such information includes, without limitation, accurate and Clean Claims for Covered Services. If [redacted] asks for additional information in order to process the Claim, Provider must provide that information within sixty (60) days, or before the expiration of the one hundred twenty (120) day period referenced in section 3.1 above, whichever is longer.

3.1.3 [redacted] will provide for prompt payment to the Provider upon receipt of a Clean Claim properly submitted by the Provider within the required time frames as specified in TCA 56-32-126. All Clean Claims will be adjudicated in accordance with the terms and conditions of a Medicaid Member's

Health Benefit Plan, the WCS, the provider manual(s), and the Regulatory Requirements applicable to [redacted] Medicaid Program(s).

3.1.4 Provider shall have one hundred and twenty (120) calendar days from the date of rendering a covered service to file a claim to [redacted] except in situations regarding (1) LEAs (Local Educational Agency) billing for IEP (Individualized Education Program), IHP (Individual Health Plan) or ISFP (Individual Family Service Plan) services and (2) coordination of benefits or subrogation in which case the provider is pursuing payment from a third party or if an enrollee is enrolled in [redacted] with a retroactive eligibility date. In situations involving LEAs, the LEA shall have three hundred and sixty-five (365) calendar days from the date of rendering a medically necessary covered IEP, IHP or IFSP service to file a claim. In situations of third-party benefits, the maximum time frames for filing a claim shall begin on the date that the third-party documented resolution of the claim. In situations of enrollment in [redacted] with a retroactive eligibility date, the time frames for filing a claim shall begin on the date [redacted] receives notification fron [redacted] of the enrollee's eligibility/enrollment.

3.2 This provision intentionally left blank.

3.3 Audit for Compliance with CMS Guidelines. Notwithstanding any other terms and conditions of the Agreement, this Attachment, or the WCS, [redacted] has the same rights as CMS, to review and/or Audit and, to the extent necessary recover payments on any claim for Medicaid Covered Services rendered pursuant to this Attachment and the Agreement to ensure compliance with CMS Regulatory Requirements.

3.4 State Audit Requirements. Provider shall maintain books, records, documents, and other evidence pertaining to Medicaid Covered Services rendered, equipment, staff, financial records, medical records, and the administrative costs and expenses incurred pursuant to this Attachment as well as medical information relating to the individual Medicaid Members, as required for the purposes of audit, or administrative, civil and/or criminal investigations and/or prosecution or for the purposes of complying with State Agency requirements regarding the reporting and investigation of fraud and abuse. Records other than medical records may be kept in an original paper state or preserved on micromedia or electronic format. Medical records shall be maintained in their original form or may be converted to electronic format as long as the records are readable and/or legible. As a condition of participation in [redacted] enrollees and providers shall give [redacted] or its authorized representative, DIDD, the Office of the Comptroller of the Treasury, and any health oversight agency, such as OIG, TBI MFCD, DHHS Office of Inspector General (DHHS OIG), and DOJ, and any other authorized state or federal agency, access to their records. Said records shall be made available and furnished immediately upon request by the provider in either paper or electronic form, at no cost to the requesting party, for fiscal audit, medical audit, medical review, utilization review, and other periodic monitoring as well as for administrative, civil and criminal investigations or prosecutions upon the request of an authorized representative of [redacted] [redacted] or authorized federal, state and Office of the Comptroller of the Treasury personnel, including, but not limited to DIDD, the OIG, the TBI MFCD, the DHHS OIG and the DOJ. Said records are to be provided by the Provider at no cost to the requesting agency; records, books, documents, etc., shall be made immediately available for any authorized federal, state agency, including, but not limited to [redacted] or its designees, Comptroller of the Treasury, the Office of the Inspector General (OIG), the Medicaid Fraud Control Division (MFCD), the Department of Health and Human Services, Office of Inspector General (DHHS, OIG) and the Department of Justice (DOJ) personnel during the Attachment period and ten (10) years thereafter, unless an audit, administrative, civil or criminal investigation or prosecution is in progress or audit findings or administrative, civil or criminal investigations or prosecutions are yet unresolved in which case records shall be kept until all tasks or proceedings are completed. Said records are to be provided by Provider at no cost to the requesting agency. During the Attachment period, Provider agrees to make these records available at a location in Tennessee as agreed upon by the parties subject to the approval State Agency. If the records need to be sent to State Agency or [redacted] Provider shall bear the expense of duplication and delivery of the medical records. Prior approval of the disposition of Provider's records must be requested and approved by State Agency. Without in any way limiting the foregoing, as a condition of receiving any amount of [redacted] or TennCarepayment, Provider shall comply with the fraud and abuse requirements set forth in the Contract Risk Agreement and the Provider Manual.

ARTICLE IV
COMPLIANCE WITH FEDERAL REGULATORY REQUIREMENTS

4.1 Federal Funds. Provider acknowledges that payments Provider receives from [redacted] to provide Medicaid Covered Services to Medicaid Members are, in whole or part, from federal funds. Therefore, Provider and any of his/her/its subcontractors are subject to certain laws that are applicable to individuals and entities receiving

federal funds, which may include but are not limited to, Title VI of the Civil Rights Act of 1964 as implemented by 45 CFR Part 80; the Age Discrimination Act of 1975 as implemented by 45 CFR Part 91; the Americans with Disabilities Act; the Rehabilitation Act of 1973 as implemented by 45 CFR part 84, lobbying restrictions as implemented by 45 CFR Part 93 and 31 USC 1352, Title IX of the Education Amendments of 1972, as amended (20 U.S.C. sections 1681, 1865-1866, and 1783) and any other regulations applicable to recipients of federal funds.

4.2 Surety Bond Requirement. If Provider provides home health services or durable medical equipment, Provider shall comply with all applicable provisions of Section 4724(b) of the Balanced Budget Act of 1997, including, without limitation, any applicable requirements related to the posting of a surety bond.

4.3 Laboratory Compliance. If Provider renders lab services in the office, it must maintain a valid Clinical Laboratory Improvement Amendments ("CLIA") certificate for all laboratory testing sites and comply with CLIA regulations at 42 CFR Part 493 for all laboratory testing sites performing Health Services pursuant to this Attachment.

4.4 Gratuities. Provider certifies that no member or delegate of Congress, nor any elected or appointed official or employee of the State of Tennessee, the United States General Accounting Office, United States Department of Health and Human Services, CMS, or any other federal agency has or will benefit financially or materially due to influence in obtaining Agreement. This Agreement may be terminated by [redacted] at the discretion of [redacted] if it is determined that gratuities of any kind were offered to or received by any of the aforementioned officials or employees from the Provider or the Provider's agent or employees.

4.5 Reassignment of Payment. Any reassignment of payment must be made in accordance with 42 CFR 447.10 and all tax-reporting entities must execute a billing agent or alternative payee assignment agreement in order to assign [redacted] funds/payments. Billing agents and alternative payees are subject to monthly federal exclusion, Tenncare's Terminated Provider List, and debarment screenings while the assignment is ongoing. Further, direct and indirect payments to out of country individuals and/or entities are prohibited.

4.6 Federal 340B Program. If Provider participates in the federal 340B program, Provider shall give [redacted] the benefit of Provider's 340B pricing. This requirement shall be enforced in accordance with the guidance as provided by [redacted]

4.7 Exclusion and Debarment Screening. Provider shall comply with all federal requirements (42 C.F.R. § 1002) on exclusion and debarment screening. Providers that bill and/or receive [redacted] funds as the result of this Participation Agreement shall screen its owners and employees against the General Services Administration (GSA) System for Award Management (SAM) and the HHS-OIG List of Excluded Individuals/Entities (LEIE). In addition, Provider shall screen its owners and employees against the Social Security Master Death File. Any unallowable funds made to excluded individuals as full or partial wages and/or benefits shall be refunded to and/or obtained by the State and/or [redacted] dependent upon the entity that identifies the payment of unallowable funds to excluded individuals.

4.7.1 Provider shall screen its employees and contractors initially and on an ongoing, monthly basis to determine whether any of them have been excluded from participation in Medicare, Medicaid, SCHIP, or any Federal health care programs (as defined in Section 1128B(f) or 1156 of the Social Security Act and 42 CFR 455.101) and not employ or contract with an individual or entity that has been excluded or debarred. The Provider shall be required to immediately report to [redacted] any exclusion information discovered. Civil monetary penalties may be imposed against providers who employ or enter into contracts with excluded individuals or entities to provide items or services to [redacted] Members.

4.8 Referral Incentive/Kickbacks. Provider agrees to abide by the Medicaid laws, regulations and program instructions that apply to the Provider. Provider understands that payment of a claim by [redacted] is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited to, the Federal anti-kickback statute and the Stark law), and is conditioned on the Provider's compliance with all applicable conditions of participation in Medicaid. The Provider understands and agrees that each claim the Provider submits to [redacted] constitutes a certification that the Provider has complied with all applicable Medicaid laws, regulations and program instructions (including, but not limited to, the Federal anti-kickback statute and the Stark law), in connection with such claims and the services provided therein.

ARTICLE V
COMPLIANCE WITH STATE REGULATORY REQUIREMENTS

5.1 Indemnification of State. In addition to the Indemnification provision of the Agreement, Provider shall, at all times, indemnify and hold harmless the State, its agencies, officers, and employees (hereinafter the "Indemnified Parties") from all claims and suits, including court costs, attorney's fees, and other expenses, brought against the Indemnified Parties, because of injuries or damages received or sustained by any person, persons, or property that is caused by any act or omission of Provider.

5.1.1 The Provider shall indemnify and hold harmless the State of Tennessee and its Indemnified Parties from all claims, losses or suits incurred by or brought against the Indemnified Parties as a result of the failure of the Provider to comply with the terms of this Attachment. The State of Tennessee shall give the Provider written notice of each such claim or suit and full right and opportunity to conduct Provider's own defense thereof, together with full information and all reasonable cooperation; but the State of Tennessee does not hereby accord to the Provider, through its attorneys, any right(s) to represent the State of Tennessee or [redacted] in any legal matter, such right being governed by TCA 8-6-106.

5.1.2 The Provider shall indemnify and hold harmless the Indemnified Parties from all claims or suits which may be brought against the Indemnified Parties for infringement of any laws regarding patents or copyrights which may arise from the Provider's or Indemnified Parties performance under this Attachment. In any such action, brought against the Indemnified Parties, the Provider shall satisfy and indemnify the Indemnified Parties for the amount of any final judgment for infringement. The State of Tennessee shall give the Provider written notice of each such claim or suit and full right and opportunity to conduct the Provider's own defense thereof, together with full information and all reasonable cooperation; but the State of Tennessee does not hereby accord to the Provider, through its attorneys, any right(s) to represent the State of Tennessee or [redacted] in any legal matter, such right being governed by TCA 8-6-106.

5.1.3 While the State of Tennessee will not provide a contractual indemnification to the Provider; such shall not act as a waiver or limitation of any liability for which the State of Tennessee may otherwise be legally responsible to the Provider. The Provider retains all of its rights to seek legal remedies against the State of Tennessee for losses the Provider may incur in connection with the furnishing of services under this Agreement or for the failure of the State of Tennessee to meet its obligations under the Agreement.

5.2 Medicaid Hold Harmless. Provider shall accept payment or appropriate denial made by Amergroup (or, if applicable, payment by [redacted] that is supplementary to the member's third party payer) plus the amount of any applicable [redacted] cost sharing responsibilities, as payment in full for Medicaid Covered Services provided to Medicaid Members. Provider agrees that in no event, including, but not limited to non-payment by [redacted] insolvency, or breach of this Attachment, shall Provider solicit or accept any surety or guarantee of payment from a Medicaid Member for Medicaid Covered Services in excess of the amount of applicable [redacted] cost sharing responsibilities. Provider agrees it shall not seek payment from the Medicaid Member, his/her representative or the State for any Health Services rendered pursuant to this Attachment, with the exception of Cost Shares, if any, or payment for non-Medicaid Covered Services otherwise requested by, and provided to, the Medicaid Member if the Medicaid Member agrees in writing to pay for the service prior to the service being rendered. Medicaid Member shall include the patient, parent(s), guardian, spouse or any other legally responsible person of the Member being served. The form of agreement must specifically state the admissions, services or procedures that are non-Medicaid Covered Services and the approximate amount of out of pocket expense to be incurred by the Medicaid Member. Provider agrees not to bill Medicaid Members for missed appointments while enrolled in the Medicaid Programs. This provision shall remain in effect even in the event [redacted] becomes insolvent.

5.3 State Agency Government Contract. Provider shall comply with the terms applicable to providers set forth in the Government Contract, including incorporated documents, between [redacted] and [redacted] which applicable terms are incorporated herein by reference. For the purposes of this Attachment all references to Government Contract shall mean and refer to [redacted] Contractor Risk Agreement ("CRA") regarding requirements for operation and administration of the managed care [redacted] program, including CHOICES and I/DD MLTSS Programs.

5.4 Performance Within the U.S. Provider agrees that all services to be performed herein shall be performed in the United States of America. Breach, or anticipated breach, of the foregoing shall be a material breach of this Attachment and, without limitation of remedies, shall be cause for immediate termination of the Agreement and this Attachment.

5.5 No Payment Outside the United States. Provider agrees that [redacted] shall not provide any payments for items or services provided under the Agreement to any financial institution or entity located outside the United States of America.

5.6 Overpayments. Notwithstanding Provider's obligation to return an overpayment upon notification from [redacted] Provider must comply with [redacted] policies and procedures regarding requirement to report, including written notification, provider initiated refunds of overpayments to [redacted] and the [redacted] Office of Program Integrity (OPI) and, when it is applicable, returning overpayments to [redacted] within sixty (60) days from the date the overpayment is identified. Overpayments that are not returned within sixty (60) days from the date the overpayment was identified may be a violation of state or federal law.

5.7 Use of Independent Review. Provider shall have the right to avail itself of the [redacted] Provider Independent Review of Disputed Claims process to resolve claims denied in whole or in part by [redacted] as provided at TCA 56-32-126(b).

5.8 Care to Pregnant Women. Any unreasonable delay in providing care to a pregnant Medicaid Member seeking prenatal care will be considered a material breach of this Attachment. "Unreasonable delay" in providing care for pregnant Medicaid Members shall mean the following: (a) for Medicaid Members in their first trimester of pregnancy, in excess of three (3) weeks from the date of the Medicaid Member's request for regular appointments and 48 hours from the date of the Medicaid Member's request for urgent care; and (b) for Medicaid Members past their first trimester of pregnancy, on the day they are determined to be eligible a first prenatal care appointment shall occur no later than fifteen (15) calendar days from the day they are determined to be eligible.

5.9 No Conflict with Government Contract. If any requirement in this Attachment is determined by [redacted] to conflict with the Government Contract provision), such requirement shall be deemed null and void, but all other provisions of this Attachment shall remain in full force and effect.

5.10 Care Coordination for CHOICES Members. Provider shall facilitate notification of the Medicaid Member's care coordinator by notifying the [redacted] in accordance with the [redacted] processes, as expeditiously as warranted by the Medicaid Member's circumstances, of any known significant changes in the Medicaid Member's condition or care, hospitalizations, or recommendations for additional services.

5.11 Cooperation with CHOICES Nursing Facility Diversion Plan. If Provider is a hospital (including a psychiatric hospital), Provider shall cooperate with [redacted] in developing and implementing protocols as part of [redacted] nursing facility diversion plan, which shall include, at a minimum, the hospital's obligation to promptly notify [redacted] upon admission of an Medicaid Member regardless of payor source for the hospitalization; how the hospital will identify members who may need home health, private duty nursing, nursing facility, or CHOICES HCBS upon discharge, and how the hospital will engage [redacted] in the discharge planning process to ensure that Medicaid Members receive the most appropriate and cost-effective Medically Necessary services upon discharge.

5.12 Ethical and Religious Directives ("ERDs"). If Provider has Ethical and Religious Directives or when a Participating Provider has conscience and religious beliefs that prevent them from providing certain Medicaid Covered Services due to those beliefs, Provider shall provide a list of the services it does not deliver due to the Ethical and Religious Directives or its conscience and religious beliefs to [redacted] shall furnish this list to [redacted] notating those services that are Medicaid Covered Services. This list shall be used by [redacted] and [redacted] to provide information to Medicaid Members about where and how the Medicaid Members can obtain the services that are not being delivered by Provider due to Ethical and Religious Directives or its conscience and religious beliefs. Should an issue arise at the time of service, the Provider shall inform Medicaid Members that [redacted] has additional information on providers and procedures that are covered by [redacted] The Provider is not required to make specific recommendations or referrals.

5.13 Pharmacy Services. Provider shall coordinate with [redacted] Pharmacy Benefit Management (PBM) regarding authorization and payment for pharmacy services.

5.14 Reporting Abuse and Neglect. Provider shall report suspected abuse, neglect, and exploitation of adults in accordance with TCA 71-6-103 and shall report suspected brutality, abuse, or neglect of children in accordance with TCA 37-1-403 and TCA 37-1-605.

5.15 Encounter Data Requirements. Provider shall submit complete and accurate utilization and/or encounter data for any services provided that are reimbursed under a global, e.g., global procedures codes for obstetric care, or capitated payment arrangement. Provider shall submit utilization and/or encounter data as specified by [redacted] in a timely manner to support individual services provided, so as to ensure [redacted] ability to submit encounter data to [redacted] that meets the same standards of completeness and accuracy as required for proper adjudication of fee-for-service claims.

5.16 Provider Change of Ownership. In the event Provider has a change of ownership, the new owner/provider shall provide to [redacted] a bill of sale (or equivalent) and documentation from the appropriate State of Tennessee licensing entity stating that the new owner is allowed to operate under the existing license until such time as a new license is issued. [redacted] shall issue a new Medicaid ID based on this provider-submitted documentation, and [redacted] shall reimburse the new provider based on rates provided by [redacted] to [redacted] on the next weekly rate file following Tenncare's receipt of the new provider's documentation. Notwithstanding this foregoing, any assignment of the Attachment shall be consistent with the Assignment provision of the Agreement.

5.17 Permitted Sanctions. In the event Provider fails to meet any performance standard or other requirement or rule of the [redacted] or any standard or rule existing under applicable law pertaining to the services provided hereunder including, without limitation, Section 1200-13-13-.08 of TennCare's Rules and regulations, or fails to perform its obligations hereunder in accordance with the terms of this Attachment, [redacted] may assess liquidated damages, sanctions or reductions in payment in an amount equal to any penalty assessed by [redacted] or under applicable law, against [redacted] due to such performance standard not having been met or due to the breach of such requirement, rule or obligation under this Attachment. Liquidated damages, sanctions or payment reductions for selected failures of performance will be specifically set forth in the provider manual.

5.18 Non-Discrimination. In addition to the Provider Non-discrimination provision of the Agreement. No person on the grounds of handicap, and/or disability, age, race, color, religion, sex, national origin, or any other classifications protected under federal or state laws shall be excluded from participation in, except as specified in Section A.2.3.5, of the Government Contract, or be denied benefits of, or be otherwise subjected to discrimination in the performance of Provider's obligation under its agreement with [redacted] or in the employment practices of the Provider. Provider shall, upon request, show proof of such nondiscrimination compliance and shall post notices of nondiscrimination in conspicuous places available to all employees, [redacted] applicants, and enrollees.

5.18.1 Provider shall provide any discrimination complaint received relating to TennCare's services and activities within two (2) days of receipt to TennCare's Office of Civil Rights Compliance ("OCRC") at HCFA.Fairtment@tn.gov. Provider agrees to cooperate with OCRC and other federal and state authorities during discrimination complaint investigations and to assist Medicaid Members in obtaining information on how they can report a complaint or get assistance for a disability related need that involves TennCare's services or activities by contacting OCRC's webpage at https://www.tn.gov/[redacted]members-applicants/civil-rights-compliance.html, to call [redacted] Connect at 855-259-0701, or to [redacted] if the member needs assistance with filing a complaint.

5.18.2 To the extent that Provider is using electronic and information technology to fulfill its obligations under this Agreement, Provider agrees to comply with the electronic and information technology accessibility requirements under the federal civil rights laws including Section 504 and Section 508 of the Rehabilitation Act of 1973 ("Section 508"), the Americans with Disabilities Act, and 45 C.F.R. pt. 92 (or any subsequent standard adopted by an oversight administrative body, including the Federal Accessibility Board). To comply with the accessibility requirements for Web content and non Web electronic documents and software, Provider shall use the most current W3C's Web Content Accessibility Guidelines ("WCAG") level AA or higher with a goal to transition to WCAG 3 level silver (For the W3C's guidelines see: https://www.w3.org/WAI/standards-guidelines/ and Section 508 standards: https://www.access-board.gov/ict/).

5.18.3 Cultural Competency. As required by 42 CFR 438.206, [redacted] and Provider shall participate in the State of Tennessee's efforts to promote the delivery of services in a culturally competent manner

to all enrollees, including those with Limited English Proficiency, disabilities and diverse cultural and ethnic backgrounds regardless of an enrollee's sex. This includes the ensuring that network providers have the capabilities to ensure physical access, reasonable accommodations, and accessible equipment for the furnishing of services to enrollees with physical or mental disabilities. Provider is required to comply with the Americans with Disabilities Act of 1990 in the provisions of any auxiliary aids and services to members and/or the member's representative to achieve effective communication.

5.18.4 Provider Discrimination Prohibition. Neither [redacted] nor Provider shall discriminate with respect to participation, reimbursement, or indemnification of a provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification. Neither [redacted] nor Provider shall discriminate against a provider for serving high-risk Members or if a provider specializes in conditions requiring costly treatments. This provision shall not be construed as prohibiting [redacted] or Provider from limiting a provider's participation to the extent necessary to meet the needs of Members. This provision also is not intended and shall not interfere with measures established by [redacted] that are designed to maintain quality of care practice standards and control costs. In addition, as a participant in a program receiving federal funds, providers shall not be subjected to discrimination because of their race, color, national origin, disability, age, sex, conscience and religious freedom, or other statuses protected by federal and/or state law.

5.19 Records Availability and Retention. In addition to the [redacted] Access to and Requests for Provider Records provision of the Agreement, Provider shall immediately make available to [redacted] [redacted] or its authorized representatives, federal or state personal, including but not limited to, OIG, TBI MFCD, DOJ and the DHHS OIG, and Office of the Comptroller of the Treasury ("Representatives"), in a usable form, any or all records, whether medical or financial, related to Provider's activities undertaken pursuant to this Attachment and the services provided to Medicaid Members. Provider shall have an adequate record system and maintain all records for ten (10) years from the termination of the Agreement or retained until all evaluations, audits reviews, investigations or prosecutions are completed for recording enrollee services, servicing providers, charges, dates and all other commonly accepted information elements for services rendered to enrollees pursuant to the Agreement (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under the Agreement and administrative, civil or criminal investigations and prosecutions).

5.19.1 Provider shall make all records (including, but not limited to, financial and medical records) pertaining to services rendered under this Attachment available at Provider's expense for administrative, civil and/or criminal review, audit, evaluation, inspection, investigation and/or prosecution by authorized federal and state personnel, including [redacted] its Representatives and [redacted] or any duly authorized state or federal designee. Access will be either through on-site review of records or mailed copies at TennCare's or the State Agency's discretion and during normal business hours, unless there are exigent circumstances, in which case access will be at any time at TennCare's or the State Agency's discretion Requested records shall be provided at no expense to [redacted] or State Agency, its Representative, [redacted] or any duly authorized state or federal designee. Paper records must be signed by rendering provider; electronic records must have capability of affixing an electronic signature to notes added by rendering provider.

5.19.2 Provider shall make all records, including, but not limited to, financial, administrative and medical records available to the State Agency, its Representatives, [redacted] or any duly authorized state or federal designee. The State Agency, its Representatives, [redacted] or any duly authorized state or federal designee or entity shall have the right to evaluate through inspection, evaluation, review or request, whether announced or unannounced, or other means, any record pertinent to this Attachment, including but not limited to medical records, billing records, financial records, and/or any records related to services rendered, quality, appropriateness and timeliness of services and/or any records relevant to an administrative, civil and/or criminal investigation and/or prosecution, and such evaluation, inspection, review or request, when performed or requested, shall be performed with the immediate cooperation of the Provider. Such records are to be provided at no charge to the requesting agency. Upon request, the Provider shall assist in such reviews, and provide complete copies of medical records. Any authorized federal or State government agency, [redacted] its Representative, [redacted] or any duly authorized state or federal designee, may use these records to carry out their authorized duties, reviews, audits, administrative, civil and/or criminal investigations and/or prosecutions.

5.19.3 [redacted] and Provider recognize that in the event of termination of the CRA between [redacted] and [redacted] for any reason(s) described therein, Provider shall immediately make available, to [redacted] or its designated representative, in a usable form, any or all records, whether medical or financial, related to the provider's activities undertaken pursuant to this Agreement. The provision of such records shall be at no expense to [redacted]

5.19.4 Provider acknowledges that HIPAA regulations do not bar disclosure of protected health information (PHI) to health oversight agencies, including, but not limited to, the Comptroller of the Treasury, OIG, MFCD, DHHS OIG and DOJ.

5.19.5 [redacted] State Agency, CMS, or their Representatives shall, at all reasonable times, have the right to enter into the Provider's premises, or such other places where duties of this Attachment are being performed, to inspect, monitor, or otherwise evaluate including periodic audits of the work being performed. The Provider shall supply reasonable access to all facilities and assistance for federal, [redacted] or State Agency's representatives.

5.20 Medical Records. Provider shall maintain medical records in a manner that is current, detailed and organized, and that permits effective and confidential patient care and quality review, administrative, civil and/or criminal investigations and/or prosecutions.

5.20.1 Provider shall have medical record keeping practices that are consistent with 42 CFR 456 and current NCQA standards for medical record documentation, in accordance with [redacted] policies and procedures regarding confidentiality of medical records, medical record documentation standards and standards for the availability of medical records. Provider shall obtain all necessary releases, consents and authorizations from Medicaid Members with respect to their medical records to permit [redacted] access to such records. Records related to appeals shall be forwarded within the timeframes specified in the appeal process section of the provider manual. Such requests made by [redacted] or [redacted] shall not be unreasonable.

5.20.2 Medical records shall be maintained and be available at the site where Medicaid Covered Services are rendered. Medicaid Members (including individuals age 16 or older for behavioral health records and including individuals age 14 or older for non-behavioral health records), and their legally appointed representatives shall be given access to the Medicaid Member's medical records, to the extent and in the manner provided by TCA 63-2-101, 63-2-102 and 33-3-104 et seq., and, subject to reasonable charges as defined in TCA 63-2-102, (except as provided section 5.20.3 below) may be given copies thereof upon request and to request that they be amended or corrected.

5.20.3 In the event a patient-provider relationship with a Medicaid Program primary care provider ends and the Medicaid Member requests that medical records be sent to a second Medicaid Program provider who will be the Medicaid Member's primary care provider, the first provider shall not charge the Medicaid Member or the second provider for providing one set of medical records.

5.20.4 If Provider furnishes Behavioral Health Care Services, Provider shall maintain medical records in conformity with TCA 33-3-101 et seq. for persons with serious emotional disturbance or mental illness. If Provider furnishes Behavioral Health Care Services, Provider shall maintain medical records of persons whose confidentiality is protected by 42 CFR Part 2 in conformity with that rule or TCA 33-3-103, whichever is more stringent. . Provider shall maintain Behavioral Health Records at the Provider level for ten (10) years from the termination of the Agreement or retained until all evaluations, audits reviews, investigations or prosecutions are completed for recording enrollee services, servicing providers, charges, dates and all other commonly accepted information elements for services rendered to enrollees pursuant to the Agreement (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under the Agreement and administrative, civil or criminal investigations and prosecutions).

5.21 Monitoring. Provider acknowledges that [redacted] may monitor the quality of services delivered by Provider hereunder and may initiate corrective action when necessary to improve quality of care in accordance with that level of medical or behavioral health care which is recognized as acceptable professional practice in the respective community in which Provider practices and/or the standards established by [redacted] Provider shall comply with corrective action plans initiated by [redacted] Provider acknowledges that [redacted] has the right to monitor Medicaid Covered Services rendered by Provider to Medicaid Members in accordance with

this Attachment and [redacted] Policies and procedures that are made known to Provider, and that such monitoring may be announced or unannounced. Provider shall participate and cooperate in any internal and external QM/QI, monitoring, utilization review, peer review and/or appeal procedures established by [redacted] and/or [redacted]

5.22 Services to [redacted] Children. Provider shall not encourage or suggest in any way that State Agency children be placed in state custody in order to receive medical, behavioral, or long-term care services covered by the Medicaid Program.

5.23 Non-Covered Services. Provider acknowleges that any services not listed in the State of Tennessee [redacted] Program Rules and Regulations Chapter 1200-13-13-.04 (or 1200-13-14-.04, as applicable) and the Government Contract at Section A.2.6 BENEFITS/SERVICES REQUIREMENTS AND LIMITS or [redacted] Bureau policies and procedures as "Covered Services" must receive prior approval in writing by [redacted] and CMS.

5.24 Reports, Provider Manual and Member Handbook. [redacted] shall provide to Provider such utilization profiles or other reports, if any, that [redacted] is required to provide to Provider under Regulatory Requirements. In addition, [redacted] shall provide its Tennessee Provider Directory to Provider. Pursuant to TCA 63-51-110, [redacted] posts an updated provider network directory on its website every twenty-one (21) business days. Provider shall timely submit all reports and clinical information required by [redacted] shall provide a copy of the applicable provider manual and Member Handbook, whether by its website or otherwise.

5.25 Conflict of Interest and Lobbying. Provider provides assurance that no part of the total Agreement amount received by Provider under this Agreement shall be paid directly, indirectly or through a parent organization, subsidiary or an affiliated organization to any state or federal officer or employee of the State of Tennessee or any immediate family member of a state or federal officer or employee of the State of Tennessee as wages, compensation, or gifts in exchange for acting as officer, agent, employee, subcontractor, or consultant to the Provider in connection with any work contemplated or performed relative to this Agreement unless otherwise disclosed to the Commissioner, Tennessee Department of Finance and Administration. For purposes of this section, "immediate family member" shall mean a spouse or minor child(ren) living in the household. Provider shall ensure that it maintains adequate internal controls to detect and prevent conflicts of interest from occurring at all levels of its organization. Provider further provides assurance that no part of the total Agreement amount received by Provider have been used, directly or indirectly, for any Lobbying activities.

5.26 Provider-Preventable Conditions. Provider understands and agrees that no payment will be made to Provider by [redacted] for any provider-preventable conditions which have been identified by [redacted] or pursuant to Regulatory Requirements. In addition, Provider shall identify provider-preventable conditions that are associated with claims for services provided under the Medicaid Program hereunder or with courses of treatment furnished to Medicaid Members for which payment under the Medicaid Program would otherwise be available.

5.27 Language and Translation Services. Provider shall be interacting with Medicaid Members from diverse cultural backgrounds, including individuals with limited English proficiency (LEP), individuals with low literacy, and individuals with disabilities, including individuals with vision, cognitive, hearing, and speech disabilities. Therefore, Provider shall have policies and procedures for delivering services in a nondiscriminatory and cultural competent manner, providing free language and communication assistance services to Medicaid Members, providing Medicaid Members with reasonable accommodations, discrimination complaint procedures, and for regularly inspecting assessment methods and any data algorithms, such as clinical algorithms, to promote equity and eliminate bias with generating assessment results. Provider shall ensure Provider's staff members carrying out the terms of the Agreement receive annual training on: Provider policies on how to deliver services in a nondiscriminatory and culturally competent manner, complaint procedures, process to obtain free language assistance services for LEP Medicaid Members, process for providing free effective communication services (auxiliary aids or services) to Medicaid Members with disabilities, and process for providing reasonable accommodations for Medicaid Members with disabilities. Provider's new hires carrying out the terms of the Agreement shall receive this training within thirty (30) days of joining Provider's workforce.

5.28 Capitation Arrangement. In the event Provider and [redacted] enter into a capitated payment arrangement for Medicaid Covered Services and Provider becomes aware for any reason that he or she is not entitled to a capitation payment for a particular enrollee (a Medicaid Member dies, for example), the Provider shall immediately notify both [redacted] and [redacted] by certified mail, return receipt requested.

5.29 Alternative Claims Processing. In the event that [redacted] deems [redacted] unable to timely process and reimburse Claims and requires [redacted] to submit Provider Claims for reimbursement to an alternative claims processor to ensure timely reimbursement, Provider shall agree to accept reimbursement at [redacted] contracted reimbursement rate or the rate established by [redacted] whichever is greater.

5.30 Informal Resolution of Disputes. Notwithstanding the Dispute Resolution and Arbitration provisions of the Agreement, in the event of a dispute arising out of this Attachment that is not resolved and Provider has exhausted any other applicable provider appeal and/or provider dispute resolution procedures under the Agreement, the parties shall seek good faith informal resolution of the dispute prior to pursuing any external remedies, subject to applicable law. Any party may initiate the informal resolution process by sending a written description of the dispute to the other parties by certified or registered mail or personal delivery. The description shall explain the nature of the dispute in detail and set forth a proposed resolution, including a specific time frame within which the parties must act. The party receiving the letter must respond in writing within thirty (30) days with a detailed explanation of its position and a response to the proposed resolution. Within thirty (30) days of the initiating party receiving this response, principals of the party who have authority to settle the dispute will meet to discuss the resolution of the dispute. The initiating party shall initiate the scheduling of the meeting. In the event the parties are unable to resolve the dispute following exhaustion of the grievance and appeal process and the negotiation or mediation, a party shall pursue remedies at law or equity.

5.31 Provider Insurance.

5.31.1 If the Provider is State owned and/or operated: The State of Tennessee, including the University of Tennessee, is prohibited by law from agreeing to provide indemnity. In addition, the General Assembly for the State of Tennessee does not authorize the State agencies or employees to provide, carry, or maintain commercial General Liability Insurance or Medical, Professional or Hospital Liability Insurance. Claims against the State of Tennessee, or its employees, for injury, damages, expenses or attorney's fees are heard and determined by the Tennessee Claims Commission or the Tennessee Board of Claims in the manner prescribed by law. See Tenn. Code Ann. §§ 8-42-101 et seq., 9-8-101 et seq., 9-8-301 et seq., and 9-8-410 et seq. Provider as a governmental entity is not required to provide workers compensation insurance. It does, however, provide a fully funded injured on duty benefit program for its employees.

5.31.2 If the Provider is a local government owned and operated: The Provider, being a Tennessee local governmental entity (such as a county or municipality), is governed by the provisions of the Tennessee Government Tort Liability Act, Tennessee Code Annotated, Sections 29-20-101 et seq., for causes of action sounding in tort. Further, no contract provision requiring a Tennessee political entity to indemnify or hold harmless the State beyond the liability imposed by law is enforceable because it appropriates public money and nullifies governmental immunity without the authorization of the General Assembly. Provider as a governmental entity is not required to provide workers compensation insurance. If the Provider does not maintain workers compensation insurance it does, however, provide a fully funded injured on duty benefit program for its employees.

5.31.3 If the Provider is a non-profit corporation duly existing and organized under the laws of the State of Tennessee which is a Federally Qualified Health Center as defined in 42 C.F.R. §405.2401, Provider is an entity to which the Federal Tort Claims Act may apply. For so long as Provider qualifies as an "employee" in accordance with Section 224 (g) of the Public Health Service Act ("PHS"), located at 42 U.S.C. § 223(g), as amended, Provider shall have its liability limits defined by Section 224(a) of the Federal Tort Claims Act. As an employee under the PHS, Provider carries no professional liability insurance; however, it is insured for general liability. This general liability insurance is for the benefit of the Provider only and provides no indemnification for any other entity whatsoever. The Provider agrees to produce proof of adequate professional liability insurance for the Provider's professional employees who perform any professional services under this Agreement and are not covered by the Federal Tort Claims Act. To the extent required by Regulatory Requirements, Provider shall maintain workers' compensation insurance for Provider's employees. In the event that Provider loses its status as an "employee" pursuant to Section 224(g) of the PHS, Provider shall maintain professional liability insurance, including maintaining such tail or prior acts coverage necessary to avoid any gap in coverage for claims arising from incidents occurring during the term of this Agreement. Such insurance shall (i) be obtained from a carrier authorized to issue coverage in the jurisdiction in which Provider operates, except for permitted self-insurance; and (ii) maintain minimum policy limits equal

to $1,000,000.00 per occurrence and $3,000,000.00 in the aggregate, or such other coverage amounts as prescribed by applicable Regulatory Requirements and consented to by [redacted] Provider shall maintain general liability insurance covering Provider's premises, insuring Provider against any claim of loss, liability, or damage caused by or arising out of the condition or alleged condition of said premises, or the furniture, fixtures, appliances, or equipment located therein, and if Provider operates motor vehicles in connection with Provider's services, with liability protection against any loss, liability or damage resulting from the operation of such motor vehicles by Provider, Provider's employees or agents. Such general liability insurance shall contain commercially reasonable coverage limits, or such limits as prescribed by Regulatory Requirements.

5.32 Behavioral Health Adverse Occurrences. Adverse occurrences shall include but not be limited to the following events when they occur while the member is in the care of a behavioral health inpatient, residential or crisis stabilization unit, or behavioral health supported housing: suicide death, non-suicide death, death-cause unkown, homicide, homicide attempt with significant medical intervention, suicide attempt with significant medical intervention, allegation of abuse/neglect (physical, sexual, verbal), accidental injury with significant medical intervention, use of restraints/seclusion (isolation) requiring significant medical intervention, or treatment complications (medication errors and adverse medication reaction) requiring significant medical intervention.

5.32.1 Provider shall report adverse occurences in accordance with applicable requirements. The maximum timeframe for reporting an adverse occurrence to [redacted] shall be twenty-four (24) business hours.

ARTICLE VI
TERMINATION

6.1 Termination of Medicaid Participation Attachment. Either party may terminate this Attachment without cause by giving at least one hundred eighty (180) days prior written notice of termination to the other party.

6.2 Termination of Government Contract. If a Government Contract between [redacted] and [redacted] terminates, expires or ends for any reason or is modified to eliminate a Medicaid Program, this Attachment shall have no further force or effect with respect to the applicable Medicaid Program. In the event of said termination, Provider shall immediately make available to [redacted] or its designees, in a usable form, any or all records, whether medical or financial, related to Provider's activities undertaken pursuant to the Government Contract. The provision of such records shall be at no expense to [redacted] or its designees.

6.3 Effect of Termination. Following termination of this Attachment, the remainder of the Agreement shall continue in full force and effect, if applicable. In addition, upon termination of this Attachment but subject to the Continuation of Care provision(s) and applicable Regulatory Requirements, any references to services, reimbursement, or participation in Networks related to the Medicaid Program are hereby terminated in full and shall have no further force and effect.

ARTICLE VII
GENERAL PROVISIONS

7.1 Regulatory Amendment. Notwithstanding the Amendment provision in the Agreement, this Attachment shall be automatically modified to conform to required changes to Regulatory Requirements related to Medicaid Programs without the necessity of executing written amendments. TennCarereserves the right to direct [redacted] to terminate or modify this Attachment when [redacted] determines it to be in the best interest of the State of Tennessee.

7.2 Inconsistencies. In the event of an inconsistency between terms and conditions of this Attachment and the terms and conditions as set forth in the Agreement, the terms and conditions of this Attachment shall govern. Except as set otherwise forth herein, all other terms and conditions of the Agreement remain in full force and effect. In the event of a) a conflict between the provisions of this Attachment and the Agreement, or b) any inconsistency or ambiguity in this Attachment, such conflict, inconsistency or ambiguity shall be resolved by giving precedence in the following order: i) state or federal law, rule, regulation or ordinance (Regulatory Requirement); ii) this Attachment; and iii) the Agreement.

7.3 Disclosure Requirements. In accordance with Regulatory Requirements, Provider agrees to disclose complete ownership, control and relationship information ("Disclosures") in accordance with 42 CFR 455.100 through 455.106. Provider further agrees to notify [redacted] within fourteen (14) days of any changes to the

Disclosures. Providers that bill and/or receive [redacted] funds as the result of the Agreement/contract shall submit routine disclosures in accordance with timeframes specified in 42 CFR Part 455, Subpart B, [redacted] and [redacted] policies and procedures, including at the time of initial contracting, contract renewal, at any time there is a change to any of the information on the disclosure form or disclosing entity, at least once every three (3) years, and at any time upon request. Providers may satisfy this requirement may be satisfied through TennCare's provider registration process. Failure to provide Disclosures as required under Regulatory Requirements shall be deemed a material breach of this Attachment and the Agreement.

7.4 Subcontracting Requirements. In addition to the Use of Subcontractors provision in the Agreement, Provider shall obtain written approval from [redacted] prior to execution of all Subcontracts for the provision of services to [redacted] Medicaid Members, subject to [redacted] submission and receipt of approval of such Subcontracts by the Tennessee Department of Commerce and Insurance. The word "subcontract" here has its usual legal meaning not the defintion used in the CRA. Failure by Provider to obtain written approval from [redacted] for a Subcontract may lead to the contract being declared null and voidby [redacted] Claims submitted by the Subcontractor or by Provider for services furnished by the unapproved subcontractor are considered to be improper payments and may be considered false claims. Any such improper payments may be subject to action under federal and state false claims statutes or be subject to be recouped by [redacted] and/or [redacted] as overpayment.

7.5 Survival of Attachment. Provider further agrees that: (1) the hold harmless and continuation of care sections shall survive the termination of this Attachment or disenrollment of the Medicaid Member; and (2) these provisions supersede any oral or written contrary agreement now existing or hereafter entered into between Provider and a Medicaid Member or persons acting on their behalf that relates to liability for payment for, or continuation of, Medicaid Covered Services provided under the terms and conditions of these provisions.

MEDICARE ADVANTAGE
PARTICIPATION ATTACHMENT TO THE
[redacted]
PROVIDER AGREEMENT

This is a Medicare Advantage Participation Attachment ("Attachment") to the [redacted] Provider Agreement ("Agreement"), entered into by and between [redacted] and Provider and is incorporated into the Agreement.

ARTICLE I
DEFINITIONS

The following definitions shall apply to this Attachment. Terms not otherwise defined in this Attachment shall carry the meaning set forth in the Agreement.

All references to '[redacted] under this Medicare Advantage Participation Attachment shall mean and refer to [redacted] Texas, Inc.

"Clean Claim" means a Claim that has no defect or impropriety, including a lack of required substantiating documentation, or particular circumstances requiring special treatment that prevents timely payment from being made on the Claim. A Claim is clean even though [redacted] refers it to a medical specialist within [redacted] for examination. If additional documentation (e.g., a medical record) involves a source outside [redacted] then the Claim is not considered clean.

"CMS" is defined as set forth in Article I of the Agreement.

"Downstream Entity(ies)" means any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the Medicare Advantage benefit, below the level of the arrangement between [redacted] and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

"Emergency Condition" is defined as set forth in the WCS.

"Emergency Services" is defined as set forth in the WCS.

"First Tier Entity(ies)" means any party that enters into a written agreement, acceptable to CMS, with [redacted] to provide administrative services or health care services for a Medicare eligible Member under the Medicare Advantage Program.

"Medically Necessary" or "Medical Necessity" means care for which CMS determines is reasonable and necessary under Medicare for services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of MA Member's medical condition and meet accepted standards of medical practice.

"Medicare" means the Health Insurance for the Aged Act, Title XVIII of the Social Security Act, as then constituted or later amended.

"Medicare Advantage Covered Services ("MA Covered Services")" means, for purposes of this Attachment, only those Covered Services provided under [redacted] Medicare Advantage Program.

"Medicare Advantage Member ("MA Member")" means, for purposes of this Attachment, a Member who is covered under a Medicare agreement between CMS and [redacted] under Part C of Title XVIII of the Social Security Act ("Medicare Advantage Program") and for [redacted] DSNP Medicare Program, the beneficiary is also entitled to Medicaid under Title XIX of the Social Security Act, see 42 USC §1396 et seq..

"Medicare Advantage Network" means Network of Providers that provides MA Covered Services to MA Members.

"Related Entity(ies)" means any entity that is related to [redacted] by common ownership or control and (1) performs some of [redacted] management functions under contract or delegation; (2) furnishes services to MA Member under an oral or written agreement; or (3) leases real property or sells materials to [redacted] at a cost of more than twenty-five hundred dollars ($2,500) during a contract period.

"Urgently Needed Care" means MA Covered Services provided when a MA Member is either: (1) temporarily absent from [redacted] Medicare Advantage service area and such MA Covered Services are Medically Necessary and immediately required: (a) as a result of an unforeseen illness, injury, or condition; and (b) it was not reasonable, given the circumstances, to obtain the services through [redacted] Medicare Advantage Network; or (2) under unusual and extraordinary circumstances, the MA Member is in the service area but [redacted] Network is temporarily unavailable or inaccessible and such MA Covered Services are Medically Necessary and immediately required: (a) as a result of an unforeseen illness, injury, or condition; and (b) it was not reasonable, given the circumstances, to obtain the services through [redacted] Medicare Advantage Network.

ARTICLE II
SERVICES/OBLIGATIONS

2.1 Participation-Medicare Advantage. As a participant in [redacted] Medicare Advantage Network, Provider will render MA Covered Services to MA Members enrolled in [redacted] Medicare Advantage Program in accordance with the terms and conditions of the Agreement and this Attachment. Except as set forth in this Attachment, or in the WCS, all terms and conditions of the Agreement will apply to Provider's participation in [redacted] Medicare Advantage Program(s). The terms and conditions set forth in this Attachment are limited to the provision of and payment for Health Services provided to MA Members. This Agreement does not apply to any of [redacted] Medicare Advantage Private Fee for Service or Medical Savings Account Programs. If [redacted] contracts with a third party to manage all or any portion of its Medicare Advantage Network, then Provider shall be required to contract separately with such third party to maintain its status as a Participating Provider for such Network(s).

2.1.1 New Programs. Provider acknowledges that [redacted] has or may develop Medicare Advantage Networks that support certain products, programs or plans with specific participation criteria that may include but are not limited to, quality and/or cost of care metrics. Pursuant to this Agreement, Provider shall be a Participating Provider in any such Network unless [redacted] notifies Provider in writing to the contrary. [redacted] shall notify Provider sixty (60) days in advance of any specific Network participation criteria. Any notice of non-inclusion in any of [redacted] Medicare Advantage Network(s) shall be provided in writing sixty (60) days in advance.

2.2 This provision intentionally left blank.

2.3 Accountability/Oversight. [redacted] delegates to Provider its responsibility under its Medicare Advantage contract with CMS to provide the services as set forth in this Attachment to MA Members. [redacted] may revoke this delegation, including, if applicable, the delegated responsibility to meet CMS reporting requirements, and thereby terminate this Attachment if CMS or [redacted] determine that Provider has not performed satisfactorily. Such revocation shall be consistent with the termination provisions of the Agreement and this Attachment. Performance of Provider shall be monitored by [redacted] on an ongoing basis as provided for in this Attachment. Provider further acknowledges that [redacted] shall oversee and is accountable to CMS for the functions and responsibilities described in the Medicare Advantage Regulatory Requirements and ultimately responsible to CMS for the performance of all services. Further, Provider acknowledges that [redacted] may only delegate such functions and responsibilities in a manner consistent with the standards as set forth in 42 CFR § 422.504(i)(4).

2.4 Accountability/Credentialing. Both parties acknowledge that accountability shall be in a manner consistent with the requirements as set forth in 42 CFR § 422.504(i)(4). Therefore the following are acceptable for purposes of meeting these requirements:

2.4.1 The credentials of medical professionals affiliated with [redacted] or Provider will be either reviewed by [redacted] if applicable; or

2.4.2 The credentialing process will be reviewed and approved by [redacted] and [redacted] must audit Provider's credentialing process and/or delegate's credentialing process on an ongoing basis.

2.5 Medicare Provider. Provider must have a provider and/or supplier agreement, whichever is applicable, with CMS that permits Provider to provide services under original Medicare.

ARTICLE III
ACCESS: RECORDS/FACILITIES

3.1 Inspection of Books/Records. Provider acknowledges that [redacted] Health and Human Services Department ("HHS"), the Comptroller General, or their designees have the right to timely access to inspect, evaluate and audit any books, contracts, medical records, patient care documentation, and other records of Provider, or his/her/its First Tier, Downstream and Related Entities, including but not limited to subcontractors or transferees involving transactions related to [redacted] Medicare Advantage contract through ten (10) years from the final date of the contract period or from the date of the completion of any audit, or for such longer period provided for in 42 CFR § 422.504(e)(4) or other Regulatory Requirements, whichever is later. For the purposes specified in this section, Provider agrees to make available Provider's premises, physical facilities and equipment, records relating to [redacted] MA Member, including access to Provider's computer and electronic systems and any additional relevant information that CMS may require. Provider acknowledges that failure to allow HHS, the Comptroller General or their designees the right to timely access under this section can subject Provider to a fifteen thousand dollar ($15,000) penalty for each day of failure to comply.

3.2 Confidentiality. In addition to the confidentiality requirements under the Agreement, each party agrees to abide by all Regulatory Requirements applicable to that party regarding confidentiality and disclosure for mental health records, medical records, other health information, and MA Member information. Provider agrees to maintain records and other information with respect to MA Member in an accurate and timely manner; to ensure timely access by MA Member to the records and information that pertain to him/her; and to safeguard the privacy of any information that identifies a particular MA Member. Information from, or copies of, records may be released only to authorized individual. Provider must ensure that unauthorized individuals cannot gain access to or alter patient records. Original medical records must be released only in accordance with Regulatory Requirements, court orders or subpoenas. Both parties acknowledge that [redacted] HHS, the Comptroller General or its designee have the right, pursuant to section 3.1 above, to audit and/or inspect Provider's premises to monitor and ensure compliance with the CMS requirements for maintaining the privacy and security of protected health information ("PHI") and other personally identifiable information ("PII") of MA Member.

ARTICLE IV
ACCESS: BENEFITS AND COVERAGE

4.1 Non-Discrimination. Provider shall not deny, limit, or condition the furnishing of Health Services to MA Member of [redacted] on the basis of any factor that is related to health status, including, but not limited to medical condition; claims experience; receipt of health care; medical history; genetic information; evidence of insurability, including conditions arising out of acts of domestic violence; or disability.

4.2 Direct Access. Provider acknowledges that MA Member may obtain covered mammography screening services and influenza vaccinations from a participating provider without a referral and that MA Member who are women may obtain women's routine and preventive Health Services from a participating women's health specialist without a referral.

4.3 No Cost Sharing. Provider acknowledges that covered influenza vaccines and pneumococcal vaccines are not subject to MA Member Cost Share obligations.

4.4 Timely Access to Care. Provider agrees to provide MA Covered Services consistent with Wellpoint's: (1) standards for timely access to care and member services; (2) policies and procedures that allow for MA Member Medical Necessity determinations; and (3) policies and procedures for Provider's consideration of MA Member input in the establishment of treatment plans.

4.5 Accessibility to Care. A Provider who is a primary care provider, or a gynecologist or obstetrician, shall provide Health Services or make arrangements for the provision of Health Services to MA Member on a twenty-four (24) hour per day, seven (7) day a week basis to assure availability, adequacy and continuity of care to MA Member. In the event Provider is not one of the foregoing described providers, then Provider shall provide Health Services to MA Member on a twenty-four (24) hour per day, seven (7) day a week basis or at such times as Health Services are typically provided by similar providers to assure availability, adequacy, and continuity of care to MA Member. If Provider is unable to provide Health Services as described in the previous sentence, Provider will arrange for another Participating Provider to cover Provider's patients in Provider's absence.

ARTICLE V
BENEFICIARY PROTECTIONS

5.1 Cultural Competency. Provider shall ensure that MA Covered Services rendered to MA Members, both clinical and non-clinical, are accessible to all MA Members, including those with limited English proficiency or reading skills, with diverse cultural and ethnic backgrounds, the homeless, and MA Members with physical and mental disabilities. Provider must provide information regarding treatment options in a cultural-competent manner, including the option of no treatment. Provider must ensure that MA Members with disabilities have effective communications with participants throughout the health system in making decisions regarding treatment options.

5.2 Health Assessment. Provider acknowledges that [redacted] has procedures approved by CMS to conduct a health assessment of all new MA Members within ninety (90) days of the effective date of their enrollment. Provider agrees to cooperate with [redacted] as necessary in performing this initial health assessment.

5.3 Identifying Complex and Serious Medical Condition. Provider acknowledges that [redacted] has procedures to identify MA Members with complex or serious medical conditions for chronic care improvement initiatives; and to assess those conditions, including medical procedures to diagnose and monitor them on an ongoing basis; and establish and implement a treatment plan appropriate to those conditions, with an adequate number of direct access visits to specialists to accommodate the treatment plan. To the extent applicable, Provider agrees to assist in the development and implementation of the treatment plans and/or chronic care improvement initiatives.

5.4 Advance Directives. Provider shall establish and maintain written policies and procedures to implement MA Members' rights to make decisions concerning their health care, including the provision of written information to all adult MA Members regarding their rights under Regulatory Requirements to make decisions regarding their right to accept or refuse medical treatment and the right to execute an advance medical directive. Provider further agrees to document or oversee the documentation in the MA Members' medical records whether or not the MA Member has an advance directive, that Provider will follow state and federal requirements for advance directives and that Provider will provide for education of his/her/its staff and the community on advance directives.

5.5 Standards of Care. Provider agrees to provide MA Covered Services in a manner consistent with professionally recognized standards of health care.

5.6 Hold Harmless. In addition to the hold harmless provision in the Agreement, Provider agrees that in no event, including but not limited to non-payment by [redacted] insolvency of [redacted] or breach of the Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a MA Member or persons other than [redacted] acting on their behalf for MA Covered Services provided pursuant to this Attachment. This section does not prohibit the collection of supplemental charges or Cost Shares on [redacted] behalf made in accordance with the terms of the MA Member's Health Benefit Plan or amounts due for services that have been correctly identified in advance as a non-MA Covered Service, subject to medical coverage criteria, with appropriate disclosure to the MA Member of their financial obligation. This advance notice must be provided in accordance with the CMS regulations for Medicare Advantage organizations. CMS regulations require that a coverage determination be made with a standard denial notice (Notice of Denial of Medical Coverage (or Payment)/CMS-10003) for a non-Covered Service when such Health Service is typically not covered, but could be covered under specific conditions. If prior to rendering the non-Covered Service, Provider obtains, or instructs the MA Member to obtain, a coverage determination of a non-Covered Service(s), the MA Member can be held financially responsible for non-Covered Services. However, if a service or item is never covered by the [redacted] such as a statutory exclusion, and the MA Member's Evidence of Coverage ("EOC") clearly specifies that the service or item is never covered, the Provider does not have to seek a coverage determination from [redacted] in order to hold the MA Member responsible for the full cost of the service or item. Additional information, related requirements and the process to request a coverage determination can be found in the Provider Guidebook. Both Parties agree that failure to follow the CMS regulations can result in Provider's financial liability.

5.6.1 Dual Eligibles. Provider further agrees that for MA Members who are dual eligible beneficiaries for Medicare and Medicaid, that Provider will ensure he/she/it will not bill the MA Member for Cost Sharing that is not the MA Member's responsibility and such MA Members will not be held liable for Medicare Parts A and B Cost Sharing when the State is liable for the Cost Sharing. In addition, Provider agrees to accept [redacted] payment as payment in full or Provider should bill the appropriate state source.

5.7 Continuation of Care-Insolvency. Provider agrees that in the event of [redacted] insolvency, termination of the CMS contract or other cessation of operations, MA Covered Services to MA Members will continue through the period for which the premium has been paid to [redacted] and services to MA Members confined in an inpatient hospital on the date of termination of the CMS contract or on the date of insolvency or other cessation of operations will continue until their discharge.

5.8 Out of Network Referrals and Transfers. In addition to the Cost Effective Care provision in the Agreement, Provider shall seek authorization from [redacted] prior to referring or transferring an MA Member to a non-Participating Provider. For [redacted] HMO Medicare Advantage Network, if a Participating Provider is not accessible or available for a referral or transfer, then Provider shall call [redacted] for an authorization. If, however, a Participating Provider is accessible and available for a referral or transfer, then Provider shall transfer or refer the MA Member to such Participating Provider. For [redacted] PPO MA Members, Provider shall advise the MA Member that an out of network referral is being made, and shall ensure that the MA Member understands and agrees to be financially responsible for any additional costs related to such out of network service.

ARTICLE VI
COMPENSATION AND AUDIT

6.1 Submission and Adjudication of Medicare Advantage Claims. Unless otherwise instructed in the provider manual(s) or Policies applicable to [redacted] Medicare Advantage Program, or unless required by Regulatory Requirements, Provider shall submit Claims to [redacted] using appropriate and current Coded Service Identifier(s), within ninety (90) days from the date the Health Services are rendered or [redacted] will refuse payment. If [redacted] is the secondary payor, the ninety (90) day period will not begin until Provider receives notification of primary payor's responsibility.

6.1.1 Provider agrees to provide to [redacted] unless otherwise instructed, at no cost to [redacted] or the MA Member, all information necessary for [redacted] to determine its payment liability. Such information includes, without limitation, accurate and Clean Claims for MA Covered Services. Once [redacted] determines [redacted] has any payment liability, all Clean Claims will be paid in accordance with the terms and conditions of a MA Member's Health Benefit Plan, the WCS, and the provider manual(s).

6.1.2 Provider agrees to submit Claims in a format consistent with industry standards and acceptable to [redacted] either (a) electronically through electronic data interchange ("EDI"), or (b) if electronic submission is not available, utilizing paper forms as defined by the National Uniform Claim Committee ("NUCC").

6.1.3 If [redacted] asks for additional information so that [redacted] may process the Claim, Provider must provide that information within sixty (60) days, or before the expiration of the ninety (90) day period referenced in section 6.1 above, whichever is longer.

6.2 Prompt Payment. [redacted] agrees to make best efforts to pay a majority of Clean Claims for MA Covered Services submitted by or on behalf of MA Members, within forty-five (45) days of receipt by [redacted] agrees to make best efforts to pay all remaining Clean Claims for MA Covered Services submitted by or on behalf of MA Members, within sixty (60) days of receipt by [redacted] agrees to make best efforts to pay all non-Clean Claims for MA Covered Services submitted by or on behalf of MA Members within sixty (60) days of receipt by [redacted] of the necessary documentation to adjudicate the Clean Claim.

6.3 Audit for Compliance with CMS Guidelines. Notwithstanding any other terms and conditions of the Agreement, [redacted] has the same rights as CMS, to review and/or Audit and, to the extent necessary recover payments on any claim for MA Covered Services rendered pursuant to this Agreement to insure compliance with CMS Regulatory Requirements.

ARTICLE VII
REPORTING AND DISCLOSURE REQUIREMENTS

7.1 Risk Adjustment Documentation and Coding Reviews and Audits. Provider is required in accordance with 42 CFR § 422.310(e) to submit medical records for MA Members for the purpose of validation of Risk Adjustment Data (as defined below in section 7.2) as requested by [redacted] Provider is also required to comply with all other medical record requests from [redacted] for other governmental (e.g., CMS, Office of Inspector General

(OIG)) and/or [redacted] documentation and coding review and audit activities. Accordingly, [redacted] or its designee, shall have the right, as set forth in section 3.4 of the Agreement to obtain copies of such documentation on at least an annual basis or otherwise as [redacted] may reasonably require. Provider agrees to provide copies of the requested medical records to [redacted] or its designee, within fourteen (14) calendar days from Wellpoint's, or its designee's, and/or any Agency's written request, unless sooner required by CMS or such other Agency. Such records shall be provided to [redacted] or its designee, or a governmental agency, at no additional cost to [redacted] its designee or such Agency. Provider also agrees to participate in education and/or remediation, as required by [redacted] based on the outcome of any documentation and coding reviews and/or audits.

7.2 Data Reporting Requirements. Provider shall provide to [redacted] all information necessary for or requested by [redacted] to enable [redacted] to meet its data reporting and submission obligations to CMS, including but not limited to, data necessary to characterize the context and purpose of each encounter between a MA Member and the Provider ("Risk Adjustment Data"), and data necessary for or requested by [redacted] to enable [redacted] to meet its reporting obligations under 42 CFR §§ 422.516 and 422.310 or under any subsequent or additional regulatory provisions or CMS guidance. In accordance with CMS Regulatory Requirements, [redacted] reserves the right to assess Provider for any penalties resulting from Provider's submission of false data.

7.3 Risk Adjustment Data Submission. Provider shall submit all diagnosis data generated in connection with this Agreement by way of filing a Claim with [redacted] Where Provider identifies supplemental diagnosis data through retrospective medical chart review or other processes, Provider shall file an amended Claim containing the supplemental diagnosis data. If an amended Claim cannot be filed and Provider wants to submit supplemental diagnosis data, then Provider shall ensure that a Claim (i.e., the associated encounter data record) has already been submitted for the original MA Member/Provider encounter. This Claim must be (i) from the same date of service, (ii) having the same Provider identification number, (iii) with the same MA Member information, and (iv) containing the same procedural information as the supplemental data identified through the retrospective medical chart review or other processes. [redacted] requires submission of the original Claim prior to the submission of supplemental data to ensure the two (2) can be linked.

Supplemental diagnosis data shall be submitted in a format specified by [redacted] If Provider reasonably determines that a Provider is unable to meet these requirements, then Provider must inform [redacted] within a reasonable time, but no later than thirty (30) days after receiving knowledge, actual or constructive of such inability, and [redacted] shall have the right to validate the data by auditing medical records and/or data generation processes, or by requesting additional data and/or documentation from Provider to confirm the acceptability of the data. For purposes of clarity, Provider shall cooperate with any such requests by [redacted] or on [redacted] behalf, as set forth in this Agreement. If Provider identifies data corrections (e.g., prior data submissions not supported in the medical record), then Provider shall promptly inform [redacted] and submit data corrections to [redacted] in a format specified by [redacted] as soon as reasonably possible, but in no event later than thirty (30) days after identifying.

7.4 Risk Adjustment Data. Provider's Risk Adjustment Data shall include all information necessary for or requested by [redacted] to enable [redacted] to submit such data to CMS as set forth in 42 CFR § 422.310 or any subsequent or additional regulatory provisions or CMS guidance. If Provider fails to submit accurate, complete, and truthful Risk Adjustment Data in the format described in 42 CFR § 422.310 or any subsequent or additional regulatory provisions or CMS guidance, then this may result in denials and/or delays in payment of Provider's Claims. [redacted] will make best efforts to work with Provider to resolve Risk Adjustment Data format and/or processing issues.

7.5 Accuracy of Risk Adjustment Data. Risk Adjustment Data submitted by Provider must be accurate, complete, and truthful. By submitting Risk Adjustment Data to [redacted] Provider is certifying and attesting to the accuracy, completeness, and truthfulness of such Risk Adjustment Data. If requested by [redacted] Provider shall execute such further certifications or attestations as to the accuracy, completeness, and truthfulness of such Risk Adjustment Data as [redacted] may require.

ARTICLE VIII
QUALITY ASSURANCE/QUALITY IMPROVEMENT REQUIREMENTS

8.1 Independent Quality Review Organization. Provider agrees to comply and cooperate with an independent quality review and improvement organization's activities pertaining to the provision of MA Covered Services for MA Member.

8.2 Compliance with [redacted] Medical Management Programs. Provider agrees to comply with [redacted] medical policies, quality improvement and performance improvement programs, and medical management programs to the extent provided to or otherwise made available to Provider in advance.

8.3 Consulting with Participating Providers. [redacted] agrees to consult with Participating Providers regarding its medical policies, quality improvement program and medical management programs and ensure that practice guidelines and utilization management guidelines: (1) are based on reasonable medical evidence or a consensus of health care professionals in the particular field; (2) consider the needs of the enrolled population; (3) are developed in consultation with participating physicians; (4) are reviewed and updated periodically; and (5) are communicated to providers and, as appropriate, to MA Member. [redacted] also agrees to ensure that decisions with respect to utilization management, MA Member education, coverage of Health Services, and other areas in which the guidelines apply are consistent with the guidelines.

ARTICLE IX
COMPLIANCE

9.1 Compliance: Medicare Laws/Regulations. Provider agrees to comply, and to require any of his/her/its subcontractors to comply, with all applicable Medicare Regulatory Requirements and CMS instructions. Further, Provider agrees that any MA Covered Services provided by Provider or his/her/its subcontractors to or on the behalf of [redacted] MA Member will be consistent with and will comply with [redacted] Medicare Advantage contractual obligations.

9.2 Compliance: Exclusion from Federal Health Care Program. Provider may not employ, or subcontract with an individual, or have persons with ownership or control interests, who have been convicted of criminal offenses related to their involvement in Medicaid, Medicare, or social services programs under Title XX of the Social Security Act, and thus have been excluded from participation in any federal health care program under §§1128 or 1128A of the Act (or with an entity that employs or contracts with such an individual) for the provision of any of the following: healthcare, utilization review, medical social work, or administrative services.

9.3 Compliance: Appeals/Grievances. Provider agrees to comply with [redacted] policies and procedures in performing his/her/its responsibilities under the Agreement. Provider specifically agrees to comply with Medicare Regulatory Requirements regarding MA Member appeals and grievances and to cooperate with [redacted] in meeting its obligations regarding MA Member appeals, grievances and expedited appeals, including the gathering and forwarding of information in a timely manner and compliance with appeals decisions.

9.4 Compliance: Policy and Procedures. Provider agrees to comply with [redacted] policy and procedures in performing his/her/its responsibilities under the Agreement and this Attachment including any supplementary documents that pertain to [redacted] Medicare Advantage Program such as the provider manual(s).

9.5 Illegal Remunerations. Both parties specifically represent and warrant that activities to be performed under this Agreement are not considered illegal remunerations (including kickbacks, bribes or rebates) as defined in 42 USCA § 1320(a)-7b.

9.6 Compliance: Training, Education and Communications. In accordance with CMS requirements, Provider agrees and certifies that it, as well as its employees, subcontractors, Downstream Entities, Related Entities and agents who provide services to or for [redacted] Medicare Advantage and/or Part D MA Members or to or for [redacted] itself shall conduct general compliance and fraud, waste and abuse training, education and/or communications annually or as otherwise required by Regulatory Requirements, and must be made a part of the orientation for a new employee, new First Tier Entities, Downstream Entities, or Related Entities, and for all new appointments of a chief executive, manager, or governing body member who performs leadership and/or oversight over the service provided under the Agreement. Provider or its subcontractors or Downstream Entities shall ensure that their general compliance and fraud, waste and abuse training and education is comparable to the elements, set forth in [redacted] Standards of Ethical Business Conduct and shall provide documentation to demonstrate compliance prior to execution of the Agreement and annually thereafter. In addition, Provider is responsible for documenting applicable employee's, subcontractor's, Downstream Entity's, Related Entity's and/or agent's attendance and completion of such training on an annual basis. Provider shall provide such documentation to [redacted] and as required to support a [redacted] or CMS audit. If necessary and upon request, [redacted] or its designee can make such compliance training, education and lines of communication available to Provider in either electronic, paper or other reasonable medium.

9.7 Federal Funds. Provider acknowledges that payments Provider receives from [redacted] to provide MA Covered Services to MA Members are, in whole or part, from federal funds. Therefore, Provider and any of his/her/its subcontractors are subject to certain Regulatory Requirements that are applicable to Members and entities receiving federal funds, which may include but is not limited to, Title VI of the Civil Rights Act of 1964 as implemented by 45 CFR Part 80; the Age Discrimination Act of 1975 as implemented by 45 CFR Part 91; the Americans with Disabilities Act; the Rehabilitation Act of 1973 as implemented by 45 CFR Part 84, lobbying restrictions as implemented by 45 CFR Part 93 and 31 USC 1352 and any other regulations applicable to recipients of federal funds.

ARTICLE X
MARKETING

10.1 Approval of Materials. Both parties agree to comply, and to require any of his/her/its subcontractors to comply, with all applicable Regulatory Requirements, CMS instructions, and marketing activities under this Agreement, including but not limited to, the Medicare Marketing Guidelines for Medicare Managed Care Plans and any requirements for CMS prior approval of materials. Any printed materials, including but not limited to letters to [redacted] MA Members, brochures, advertisements, telemarketing scripts, packaging prepared or produced by Provider or any of his/her/its subcontractors pursuant to this Agreement must be submitted to [redacted] for review and approval at each planning stage (i.e., creative, copy, mechanicals, blue lines, etc.) to assure compliance with Regulatory Requirements. [redacted] agrees its approval will not be unreasonably withheld or delayed.

ARTICLE XI
TERMINATION

11.1 Notice Upon Termination. If [redacted] decides to terminate this Attachment, [redacted] shall give Provider written notice, to the extent required under CMS regulations, of the reasons for the action, including, if relevant, the standards and the profiling data the organization used to evaluate Provider and the numbers and mix of Participating Providers needs. Such written notice shall also set forth Provider's right to appeal the action and the process and timing for requesting a hearing.

11.2 Effect of Termination. Following termination of this Attachment, the remainder of the Agreement shall continue in full force and effect, if applicable. In addition, upon termination of this Attachment but subject to the Continuation of Care provision(s) and applicable Regulatory Requirements, any references to services, reimbursement, or participation in Networks related to the Medicare Advantage Program are hereby terminated in full and shall have no further force and effect.

11.3 Termination Without Cause. Either party may terminate this Attachment without cause by giving at least one hundred twenty (120) days prior written notice of termination to the other party.

ARTICLE XII
GENERAL PROVISIONS

12.1 Inconsistencies. In the event of an inconsistency between terms of this Attachment and the terms and conditions as set forth in the Agreement, the terms and conditions of this Attachment shall govern. Except as set forth herein, all other terms and conditions of the Agreement remain in full force and effect.

12.2 Interpret According to Medicare Laws. Provider and [redacted] intend that the terms of the Agreement and this Attachment as they relate to the provision of MA Covered Services under the Medicare Advantage Program shall be interpreted in a manner consistent with applicable requirements under Medicare Regulatory Requirements.

12.3 Subcontractors. In addition to the Use of Subcontractors provision of the Agreement, Provider agrees that if Provider enters into subcontracts to perform services under the terms of this Attachment, Provider's subcontracts shall include: (1) an agreement by the subcontractor to comply with all of Provider's obligations in the Agreement and this Attachment; (2) a prompt payment provision as negotiated by Provider and the subcontractor; (3) a provision setting forth the term of the subcontract (preferably one (1) year or longer); and (4) dated signatures of all the parties to the subcontract.

12.4 Delegated Activities. If [redacted] has delegated activities to Provider, then [redacted] will provide the following information to Provider and Provider shall provide such information to any of its subcontracted entities:

12.4.1 A list of delegated activities and reporting responsibilities;

12.4.2 Arrangements for the revocation of delegated activities;

12.4.3 Notification that the performance of the contracted and subcontracted entities will be monitored by [redacted]

12.4.4 Notification that the credentialing process must be approved and monitored by [redacted] and

12.4.5 Notification that all contracted and subcontracted entities must comply with all applicable Medicare Regulatory Requirements and CMS instructions.

12.5 Delegation of Provider Selection. In addition to the responsibilities for delegated activities as set forth herein, to the extent that [redacted] has delegated selection of providers, contractors, or subcontractor to Provider, [redacted] retains the right to approve, suspend, or terminate any such arrangement.

12.6 Survival of Attachment. Provider further agrees that: (1) the hold harmless and continuation of care sections shall survive the termination of this Attachment or disenrollment of the MA Member; and (2) these provisions supersede any oral or written contrary agreement now existing or hereafter entered into between Provider and an MA Member or persons acting on their behalf that relates to liability for payment for, or continuation of, MA Covered Services provided under the terms and conditions of these clauses.

12.7 Attachment Amendment. Notwithstanding the Amendment provision in the Agreement, this Attachment shall be automatically modified to conform to required changes to Regulatory Requirements related to Medicare Advantage Programs without the necessity of executing written amendments. For amendments not required by Regulatory Requirements related to Medicare Advantage Programs, [redacted] shall make a good faith effort to provide notice to Provider at least thirty (30) days in advance of the effective date of the amendment.

12.8 References to Regulatory Requirements. All references in this Attachment to any Regulatory Requirement shall mean and refer to the existing law, regulation or guidance as of the Effective Date of the Agreement and any subsequent, successor or additional Regulatory Requirements related to the same subject matter.

NURSING FACILITY SERVICES
PARTICIPATION ATTACHMENT TO THE
[redacted]
PROVIDER AGREEMENT

This is a Nursing Facility Services Participation Attachment ("Attachment") to the [redacted] Provider Agreement ("Agreement"), entered into by and between [redacted] and Provider and is incorporated into the Agreement.

ARTICLE I
OBLIGATIONS OF THE PARTIES

NOW, THEREFORE, for good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree as follows.

1.1 Clean Claim. "Clean Claim" means a request for payment for a service rendered by Provider that (a) is timely submitted by Provider; (b) is accurate; (c) is submitted on a HIPAA compliant standard claim form including a CMS 1500 (08-05) or UB-04 CMS 1450 or successor forms thereto or the electronic equivalent of such claim form; (d) is a complete claims submission following any and all HIPAA compliance standards (Levels1-7); (e) includes National Provider Identifier and Taxonomy information for Rendering, Attending and Billing providers; (f) includes, for all J-codes billed, NDC code and drug pricing information (NDC quantity, unit price and unit of measurement) are required, exceptions are: vaccines for children which are paid as an administrative fee, inpatient administered drugs, radiopharmaceuticals unless the drug is billed separately from the procedure; and that requires no further information, adjustment, or alteration by Provider in order to be processed and paid by [redacted] A Claim is "timely submitted" under this Agreement if it is submitted within the timeframes required by this Agreement. A Clean Claim includes resubmitted Claims with previously identified deficiencies corrected and is resubmitted within the timeframes required by this Agreement.

1.2 Adult and Children Protective Services. Provider agrees to report suspected abuse, neglect, and exploitation of adults in accordance with TCA 71-6-103 to the Tennessee Department of Human Services and to report suspected brutality, abuse, or neglect of children in accordance with TCA 37-1-403 and TCA 37-1-605 to the Tennessee Department of Children's Services.

1.3 Member Care Coordinator Notification. Provider shall notify a Member's care coordinator of any significant changes in the Member's needs or care, hospitalizations, emergency room visits or recommendations for additional Medicaid Covered Services. [redacted] will notify the Provider in writing of all assigned care coordinators for each Member in their facility.

1.4 Notification to [redacted] Hospitals, including psychiatric hospitals shall cooperate pursuant to CRA Sections 2.9.6.7 and 2.9.6.8 with [redacted] in developing and implementing protocols as part of [redacted] nursing facility diversion plan which shall include, at a minimum, the hospital's obligation to promptly notify [redacted] upon admission of an eligible Member regardless of payor source for the hospitalization; how the hospital will identify Members who may need home health, private duty nursing, nursing facility, or Home and Community Based Services ("HCBS") upon discharge, and how the hospital will engage [redacted] in the discharge planning process to ensure that Members receive the most appropriate and cost-effective medically necessary services upon discharge.

1.5 Critical Incident Reporting and Management.

1.5.1 Provider shall report, respond to, and document critical incidents as specified by [redacted] in accordance with Government Contract Section 2.15.8. This shall include, but not be limited to the following:

1.5.1.1 Provider shall report critical incidents to [redacted] in accordance with applicable requirements. [redacted] shall develop and implement a critical incident reporting process, including the form to be used to report critical incidents and reporting timeframes. The maximum timeframe for reporting an incident to [redacted] shall be twenty-four (24) hours. The initial report of an incident within twenty-four (24) hours may be submitted verbally, in which case the person/agency/entity making the initial report shall submit a follow-up written report within forty-eight (48) hours.

1.5.1.2 Provider shall ensure that its staff and contract long-term care providers immediately take effective steps to prevent further harm to any and all Members and respond to any emergency needs of Members.

1.5.1.3 Provider shall ensure in the event of a critical incident, Provider shall conduct an internal critical incident investigation and submit a report on the investigation within the timeframe specified by [redacted] The timeframe for submitting the report shall be as soon as possible, may be based on the severity of the incident, and, except under extenuating circumstances, shall be no more than thirty (30) days after the date of the incident. [redacted] shall review the Provider's report and follow-up with the Provider as necessary to ensure that an appropriate investigation was conducted and corrective actions were implemented within applicable timeframes.

1.5.1.4 Provider shall cooperate with any investigation conducted by [redacted] or outside agencies (e.g., State Agency, Adult Protective Services (APS), Child Protective Services (CPS), and law enforcement).

1.5.1.5 Provider shall provide appropriate training and taking corrective action as needed to ensure its staff, contract providers, the FEA, and workers comply with critical incident requirements.

1.5.1.6 Provider shall conduct oversight, including but not limited to oversight of its staff, contract long-term care providers, and the FEA, to ensure that [redacted] policies and procedures are being followed and that necessary follow-up is being conducted in a timely manner.

1.6 Criminal Background Checks. In accordance with applicable Regulatory Requirements, Provider shall perform criminal background checks for all employed or contracted individuals providing Medicaid Covered Services under this Agreement.

1.7 Transfers and Discharges. Long-term Care Facilities participating in the Medicaid Program must comply with the following guidelines regarding transfers, discharges and/or readmissions.

1.7.1 Transfer and Discharge Rights. A Long-term Care Facility must permit each resident to remain in the facility and must not transfer or discharge the resident from the facility unless;

1.7.1.1 The transfer or discharge is necessary to meet the resident's welfare which cannot be met in the facility;

1.7.1.2 The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;

1.7.1.3 The safety of individuals in the facility is endangered;

1.7.1.4 The health of individuals in the facility would otherwise be endangered;

1.7.1.5 The resident has failed, after reasonable and appropriate notice, to pay (or to have paid under Title XIX or Title XVIII on the resident's behalf) for a stay at the facility; or

1.7.1.6 The facility ceases to operate.

1.7.1.7 In each of the cases described above, no patient shall be discharged or transferred without a written order from the attending physician or through other legal processes and timely notification of next of kin and/or sponsor or authorized representative, if any. Each Long-term Care Facility shall establish a policy for handling patients who wish to leave the facility against medical advice. The basis for the transfer or discharge must be documented in the resident's clinical record. In the cases described in the clauses 1.7.1.1 and 1.7.1.2, the documentation must be made by the resident's physician, and in the case described in clause 1.7.1.4 the documentation must be made by a physician. For purposes of clause 1.7.1.5, in the case of a resident who becomes eligible for assistance under Title XIX after admission to the facility, only charges which may be imposed under Title XIX shall be considered to be allowable. When a patient is transferred, a summary of treatment given at the facility, condition of patient at time of transfer and date and place to which transferred shall be entered in the record. If transfer is due to an emergency; this information will be recorded within forty-eight (48) hours; otherwise, it will precede the transfer of the patient. When a patient is transferred, a copy of the clinical summary should, with consent of the patient, be sent to the Long-term Care Facility that will continue the care of the patient. Where

an involuntary transfer is proposed, in addition to any other relevant factors, the following factors shall be taken into account:

1.7.1.7.1 The traumatic effect on the patient.

1.7.1.7.2 The proximity of the proposed Long-term Care Facility to the present facility and to the family and friends of the patient.

1.7.1.7.3 The availability of necessary medical and social services at the proposed Long-term Care Facility.

1.7.1.7.4 Compliance by the proposed Long-term Care Facility with all applicable Federal and State regulations.

1.7.2 Pre-Transfer and Pre-Discharge Notice. Before effecting a transfer or discharge of a resident, a Long-term Care Facility must:

1.7.2.1 Notify- the resident (and, if known, a family member of the resident or legal representative) of the transfer or discharge and the reasons therefore.

1.7.2.2 Record the reasons in the resident's clinical record (including any documentation required pursuant to 1.7.1 above) and include in the notice the items described in 1.7.4 below.

1.7.2.3 Notify the Department and the long-term care Ombudsman.

1.7.2.4 Not transfer or discharge a resident until the above agencies have designated their intention to intervene and until any appeal process is complete, should the resident request a fair hearing.

1.7.3 Timing of Notice. The notice under 1.7.2 must be made at least thirty (30) days in advance of the resident's transfer or discharge except:

1.7.3.1 In a case described in 1.7.1.3 above.

1.7.3.2 In a case described in 1.7.1.2 where the resident's health improves sufficiently to allow a more immediate transfer or discharge.

1.7.3.3 In a case described in 1.7.1.1 where a more immediate transfer or discharge is necessitated by the resident's urgent medical needs.

1.7.3.4 In a case where a resident has not resided in the facility for thirty (30) days. In the case of such exceptions, notice must be given as many days before the date of transfer or discharge as is practicable

1.7.4 Items Included in Notice. Each pre-transfer and pre-discharge notice under 1.7.2 must include:

1.7.4.1 For transfers or discharges effected on or after October 1, 1990, notice of the resident's right to appeal the transfer or discharge.

1.7.4.2 The name, mailing address, and telephone number of the long-term care ombudsman.

1.7.4.3 In the case of residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy system for developmentally disabled individuals.

1.7.4.4 In the case of mentally ill residents, the mailing address and telephone number of the agency responsible for the protection and advocacy system for mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.

1.7.5 Orientation. A Long-term Care Facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer OT discharge from the facility.

1.7.6 Notice of Bed-Hold Policy and Readmission. Before a resident of a Long-term Care Facility is transferred for hospitalization or therapeutic leave, a Long-term Care Facility must provide written information to the resident and a family member or legal representative concerning:

1.7.6.1 The provisions of the State plan under this Title XIX regarding the period (if any) during which the resident will be permitted under the State plan to return and resume residence in the facility, and

1.7.6.2 The policies of the facility consistent with 1.7.7 below, regarding such a period.

1.7.7 Notice Upon Transfer. At the time of transfer of a resident to a hospital or for therapeutic leave, a Long-term Care Facility must provide written notice to the resident and a family member or legal representative of the duration of any period under the State plan allowed for the resumption of residence in the facility.

1.8 Cost Sharing Requirements. Provider shall collect appropriate patient liability amounts from CHOICES Group 1 Members, notifying the Member's care coordinator if there is an issue with collecting Member's patient liability, and the Provider must demonstrate and document a good faith effort in collecting patient liability amounts.

1.9 CRG/TPG Assessments. Pursuant to this Agreement, if Provider furnishes Clinically Related Group (CRG) and Target Population Group (TPG) assessments, Provider is responsible for ensuring that all CRG/TRG assessments are completed by State-certified raters and that the assessments are completed within fourteen (14) days of a request. The rater certification process shall include completing the CRG/TPG assessments training and passing the State rater competency examination scored only by State-certified trainers. [redacted] will conduct audits of any CRG/TPG assessments for accuracy and conformity to state policies and procedures. [redacted] shall audit the Provider's conduct of these assessments on at least an annual basis. The methodology for these audits and the results of these audits will be reported as required by [redacted] to the applicable State Agency.

1.10 Additional Government Contract Requirements. Nursing Facility Providers agree to:

1.10.1 Promptly notify [redacted] and/or State entity as directed by the applicable State Agency, of a Member's admission or request for admission to the nursing facility regardless of payor source for the nursing facility stay, or when there is a change in a Member's known circumstances and to notify [redacted] prior to a Member's discharge;

1.10.2 Ensure, as a condition of payment for Medicaid Covered Services, that there is a timely certification and recertification (as applicable) of the Member's level of care eligibility for Level I and/or Level II nursing facility care, to cooperate fully with [redacted] in the completion and submission of the level of care assessment, and to notify [redacted] of any change in the Member's medical or functional condition which could impact the Member's level of care eligibility for the currently authorized level of nursing facility services;

1.10.3 Comply with state and federal laws and regulations applicable to nursing facilities as well as any applicable federal court orders, including but not limited to those which govern admission, transfer, and discharge policies;

1.10.4 Comply with federal Pre-Admission Screening and Resident Review (PASRR) requirements applicable to all nursing facility residents, regardless of payor source, including that a level I screening be completed prior to admission, a level II screening be completed when indicated by the level I screening, and a review be completed based upon a significant physical or mental change in the resident's condition which might impact the Member's need for or benefit from specialized services; the facility shall collaborate with [redacted] and with other Providers as needed to help ensure that current information regarding the Member's mental health or intellectual disabilities needs (as available) is reflected in the PASRR screening in order to support an appropriate PASRR determination;

1.10.5 Cooperate with [redacted] in developing and implementing protocols as part of [redacted] nursing facility diversion and transition plans, which shall, include, at a minimum, the nursing facility's obligation to promptly notify [redacted] upon admission or request for admission of an eligible Member regardless of payor source for the nursing facility stay; how the nursing facility will assist [redacted] in identifying residents who may want to transition from nursing facility services to home and community-based care; the nursing facility's obligation to promptly notify [redacted] regarding all such identified Members; and how the nursing facility will work with

[redacted] in assessing the Member's transition potential and needs, and in developing and implementing a transition plan, as applicable;

1.10.6 Have on file a system designed and utilized to insure the integrity of the Member's personal financial resources. This system shall be designed in accordance with the regulations and guidelines set out by the Comptroller of the Treasury and the applicable federal regulations;

1.10.7 Immediately notify [redacted] of any change in its license to operate as issued by the Tennessee Department of Health as well as any deficiencies cited during the federal certification process;

1.10.8 That if the nursing facility provider is involuntarily decertified by the Tennessee Department of Health or the Centers for Medicare and Medicaid Services, the provider agreement will automatically be terminated.

1.10.9 That the provider agreement shall be assignable from [redacted] to the State, or its designee, at the State's discretion upon written notice to [redacted] and the affected nursing facility provider. Further, the provider agreement shall include language by which the nursing facility provider agrees to be bound by any such assignment, and that the State, or its designee, shall not be responsible for past obligations of [redacted]

1.10.10 Require the nursing facility to provide advance written notice to [redacted] and the applicable State Agency before voluntarily terminating the agreement and specify the timeframe for providing such notice.

1.10.11 Require the nursing facility provider to notify [redacted] immediately if the nursing facility is considering discharging a Member and to consult with the Member's care coordinator to intervene in resolving issues if possible and, if not, to prepare and implement a discharge and/or transition plan as appropriate.

1.10.12 Require the nursing facility to notify the Member and /or the Member's representative (if applicable) in writing prior to discharge in accordance with state and federal requirements.

1.10.13 Require the nursing facility provider to coordinate with [redacted] in complying with the requirements in 42 CFR 483.75 regarding written transfer agreements and shall use contract providers when transfer is medically appropriate, except as authorized by [redacted] or for emergency services.

1.10.14 Develop protocols and processes to work with nursing facilities to coordinate the provision of care. At minimum, a care coordinator assigned to a resident to the nursing facility shall participate in Grand Rounds quarterly, at least two of which shall be conducted onsite in the facility, and the Grand Rounds shall identify and address any Member who has experienced a potential significant change in needs or circumstances or about whom the nursing facility has expressed concerns.

1.10.15 Develop and implement with [redacted] targeted strategies to improve health, functional, or quality of life outcomes, e.g., related to disease management or pharmacy management, or to increase and/or maintain functional abilities.

1.10.16 Coordinate with [redacted] as necessary to facilitate access to physical health and/or behavioral health services needed by the Member to help ensure the proper management of the Member's acute and/or chronic health conditions including services covered by [redacted] that are beyond the scope of the nursing facility services benefit. At a minimum, the nursing facility shall consider the following a potential significant change in needs or circumstances for Members who are residing in a nursing facility:

1.10.16.1 Pattern of recurring falls

1.10.16.2 Incident injury or complaint

1.10.16.3 Report of abuse or neglect

1.10.16.4 Frequent hospitalizations, or

1.10.16.5 Prolonged or significant change in health and/or functional status.

1.10.17 Require nursing facility to screen their employees and contractors initially and on an ongoing monthly basis to determine whether any of them has been excluded from participation in Medicare, Medicaid, State

Children's Health Insurance Program (SCHIP), or any Federal health care programs (as defined in Section 1128B(f) of the Social Security Act) and not employ or contract with an individual or entity that has been excluded. The nursing facility shall be required to immediately report to [redacted] any exclusion information discovered. The nursing facility shall be informed that civil monetary penalties may be imposed against Providers who employ or enter into contracts with excluded individuals or entities to provide items or services to the applicable State Agency Medicaid Members.

1.10.18 The Nursing Facility shall accept payment or appropriate denial made by [redacted] (or, if applicable, payment by [redacted] that is supplementary to the Member's third party payer) plus the amount of any applicable patient liability, as payment in full for Medicaid Covered Services provided and shall not solicit or accept any surety or guarantee of payment from the Member in excess of the amount of applicable patient liability responsibilities. Member shall include the patient, parent(s), guardian, spouse or any other legally responsible person of the Member being served

1.10.19 When there is a change of ownership with any Nursing Facility, the new legal entity shall provide to the applicable State Agency a bill of sale (or equivalent) and documentation from the appropriate State licensing entity stating that the new legal entity is allowed to operate under the existing license until such time as a new license is issued. The applicable State Agency shall issue a new Medicaid ID based on this provider-submitted documentation, and [redacted] shall enter into a provider agreement with the new provider prior to the effective date of the change of ownership. A new provider with a Medicaid ID and a provider agreement with [redacted] which shall include, but not be limited to, the assumption of the previous owner's agreement, a new agreement with [redacted] or a single case agreement, shall be reimbursed at one hundred percent (100%) from the effective date of the change of ownership. For purposes of nursing facility changes of ownership only, [redacted] may provisionally credential the new provider based on credentialing completed for the previous provider to enable execution of an agreement prior to the change of ownership. In cases where the [redacted] utilizes provisional credentialing, [redacted] shall subsequently conduct credentialing of the provider once the change of ownership process has fully concluded (including any actions related to licensure and/or certification). A new provider with a change of ownership that has not acquired a Medicaid ID shall not be reimbursed, including retroactively, until such provider acquires a Medicaid ID.

1.10.20 In the event the contract is terminated because of a change of ownership, [redacted] shall remain obligated to pay for reimbursable services rendered prior to termination of the contract and that become due after the contract is terminated subject to timely filing requirements.

1.11 The Nursing Facility shall submit complete and accurate PAEs that satisfy all technical requirements specified by the applicable State Agency, and accurately reflect the Member's current medical and functional status, including Safety Determination Requests. The nursing facility shall also submit all supporting documentation required in the PAE and Safety Determination Request Form, as applicable and required pursuant to the applicable State Agency Rules.

1.12 To the extent Provider will be contracted to provide Ventilator Care, the Payment Attachment shall specify whether the Provider will be contracted to provide SNF services at an ERC rate for Ventilator Weaning, Chronic Ventilator Care, and/or Tracheal Suctioning in addition to standard NF and SNF services (each level of ERC reimbursement must be uniquely identified). When the Agreement provides for SNF services at an enhanced rate for ventilator weaning, chronic ventilator care, and/or tracheal suctioning, [redacted] shall verify prior to provision of Medicaid Covered Services that the facility has been licensed by the Tennessee Department of Health to provide such specialized ERC, is certified by CMS for program participation, and is compliant with threshold standards of care for the applicable type of ERC and requirements for ERC reimbursement established by the applicable State Agency.

1.13 Non-Discrimination. Provider shall abide by the federal Civil Rights Act of 1964, the Federal Rehabilitation Act of 1973, and all other applicable statutes, regulations and orders (including, without limitation, Executive Orders 11246 and 11375, "Equal Employment Opportunities") as amended, and any and all successor statutes, regulations and related orders. Provider shall not exclude any Medicaid Member from participation in any aid, care, service or other benefit, or deny any Medicaid Member such Medicaid Covered Services on the grounds of handicap, and/or disability, age, race, color, religion, sex, national origin or any other classifications protected under federal or state laws, or be denied benefits of, or be otherwise subjected to discrimination in the performance of Provider's obligation under its agreement with [redacted] or in the employment practices of the Provider. Provider will cooperate with the applicable State Agency and/or CMS, and [redacted] as applicable, during discrimination complaint investigations. The Provider will assist any Medicaid Member in obtaining discrimination complaint forms and contact information for [redacted] Nondiscrimination Office. Provider shall upon request show proof of such nondiscrimination compliance and shall

post notices of nondiscrimination in conspicuous places available to all employees, the applicable State Agency applicants, and Medicaid Member's.

[redacted] **COMPENSATION SCHEDULE ("WCS")**

ARTICLE I
DEFINITIONS

The definitions set forth below shall apply with respect to all of the terms outlined in this WCS. Terms not otherwise defined in this WCS and defined elsewhere in the Agreement shall carry the meanings set forth in the Agreement.

"Capitation" means the amount paid by [redacted] to a provider or management services organization on a per member per month basis for either specific services or the total cost of care for Covered Services.

"Case Rate" means the all-inclusive [redacted] Rate for an entire admission or one outpatient encounter for Covered Services.

"Chargemaster" or "Charge Master" means facility's listing of facility charges for products, services and supplies.

"Coded Service Identifier(s)" means a listing of descriptive terms and identifying codes, updated from time to time by CMS or other industry source, for reporting Health Services on the CMS 1500 or CMS 1450/UB-04 claim form or its successor as applicable based on the services provided. The codes include but are not limited to, American Medical Association Current Procedural Terminology ("CPT®-4"), CMS Healthcare Common Procedure Coding System ("HCPCS"), International Classification of Diseases, 10th Revision ("ICD-10"), National Uniform Billing Committee ("Revenue Code") and National Drug Code ("NDC") or their successors.

"Cost to Charge Ratio" ("CCR") means the quotient of cost (total operating expenses minus other operating revenue) divided by charges (gross patient revenue) expressed as a decimal, as defined by Regulatory Requirements.

"Diagnosis-Related Group" ("DRG") means Diagnosis Related Group or its successor as established by CMS or other grouper, including but not limited to, a state mandated grouper or other industry standard grouper.

"DRG Rate" means the all-inclusive dollar amount which is multiplied by the appropriate DRG Weight to determine the [redacted] Rate for Covered Services.

"DRG Weight" means the weight applicable to the specific DRG methodology set forth in this WCS, including but not limited to, CMS DRG weights as published in the Federal Register, state agency weights, or other industry standard weights.

"Eligible Charges" means those Provider Charges that meet [redacted] conditions and requirements for a Health Service to be eligible for reimbursement. These conditions and requirements include but are not limited to: Member program eligibility, Provider program eligibility, benefit coverage, authorization requirements, provider manual specifications, [redacted] administrative, clinical and reimbursement policies and methodologies, code editing logic, coordination of benefits, Regulatory Requirements, and this Agreement. Eligible Charges do not include Provider Charges for any items or services that Provider receives and/or provides free of charge.

"Emergency Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the health of the individual, or in the case of a pregnant woman, the health of the woman or her unborn child; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

"Emergency Services" means those Covered Services furnished by a provider qualified to furnish emergency services, and which are needed to evaluate or treat an Emergency Condition.

"Encounter Data" means Claim information and any additional information submitted by a provider under capitated or risk-sharing arrangements for Health Services rendered to Members.

"Encounter Rate" means the [redacted] Rate that is all-inclusive of professional, technical and facility charges including evaluation and management, pharmaceuticals, routine surgical and therapeutic procedures, and diagnostic testing (including laboratory and radiology) capable of being performed on site.

"Fee Schedule(s)" means the complete listing of [redacted] Rate(s) for specific services that is payment for each unit of service allowed based on applicable Coded Service Identifier(s) for Covered Services.

"Global Case Rate" means the all-inclusive [redacted] Rate which includes facility, professional and physician services for specific Coded Service Identifier(s) for Covered Services.

"Inpatient Services" means Covered Services provided by a facility to a Member who is admitted and treated as a registered inpatient, is assigned a licensed bed within the facility, remains assigned to such bed and for whom a room and board charge is made.

"Observation" means the services furnished on the facility's premises, including use of a bed and periodic monitoring by nursing or other staff, which are Medically Necessary to evaluate a Member's condition and determine if the Member requires an inpatient admission to the facility. Such determination shall be in compliance with Policies or Regulatory Requirements.

"Outlier Rate" means the payment applied to an admission which exceeds the outlier threshold as set forth in the WCS or in compliance with Policies or Regulatory Requirements.

"Outpatient Services" means Covered Services provided by a facility to a Member who is admitted and treated as a registered outpatient within the facility.

"Patient Day" means each approved calendar day of care that a Member receives in the facility, to the extent such day of care is a Covered Service under the terms of the Member's Health Benefit Plan, but excluding the day of discharge.

"Percentage Rate" means the [redacted] Rate that is a percentage of Eligible Charges billed by a provider for Covered Services.

"Per Diem Rate" means the [redacted] Rate that is the all-inclusive fixed payment for Covered Services rendered on a single date of service.

"Per Hour Rate" means the [redacted] Rate that is payment based on an increment of time for Covered Services.

"Per Relative Value Unit" ("RVU") means the [redacted] Rate for each unit of service based on the CMS, State Agency or other (e.g., American Society of Anesthesiologists (ASA)) defined Relative Value Unit (RVU).

"Per Service Rate" means the [redacted] Rate that is payment for each service allowed based on applicable Coded Service Identifier(s) for Covered Services.

"Per Unit Rate" means the [redacted] Rate that is payment for each unit of service allowed based on applicable Coded Service Identifier(s) for Covered Services.

"Per Visit Rate" means the [redacted] Rate that is the all-inclusive fixed payment for one encounter for Covered Services.

"Provider Charges" means the regular, uniform rate or price Provider determines and submits to [redacted] as charges for Health Services provided to Members. Such Provider Charges shall be no greater than the rate or price Provider submits to any person or other health care benefit payor for the same Health Services provided, regardless of whether Provider agrees with such person or other payor to accept a different rate or price as payment in full for such services.

"Short Stay" means an inpatient hospital stay that is less than a specified number of calendar days in compliance with Policies and/or Regulatory Requirements.

ARTICLE II
GENERAL PROVISIONS

Billing Form and Claims Reporting Requirements. Provider shall submit all Claims on a CMS 1500 or CMS 1450/UB-04 claim form or its successor form(s) as applicable based on the Health Services provided in accordance with Policies or applicable Regulatory Requirements. Provider shall report all Health Services in accordance with the Coded Service Identifier(s) reporting guidelines and instructions using HIPAA compliant billing codes. In addition, [redacted] shall not pay any Claim(s) nor accept any Encounter Data submitted using non-compliant codes. [redacted] audits that result in

identification of Health Services that are not reported in accordance with the Coded Service Identifier(s) guidelines and instructions, will be subject to recovery through remittance adjustment or other recovery action as may be set forth in the provider manual(s).

Claim Submissions for Pharmaceuticals. Each Claim submitted for a pharmaceutical product must include standard Coded Service Identifier(s), a National Drug Code ("NDC") number of the covered medication, a description of the product, and dosage and units administered.

Coding Updates. Coded Service Identifier(s) used to define specific rates are updated from time to time to reflect new, deleted or replacement codes. [redacted] shall use commercially reasonable efforts to update all applicable Coded Service Identifiers within sixty (60) days of release by CMS or other applicable authority. When billing codes are updated, Provider is required to use appropriate replacement codes for Claims for Covered Services, regardless of whether this Agreement has been amended to reflect changes to standard billing codes. If Provider bills a revised code prior to the effective date of the revised code, the Claim will be rejected or denied and Provider shall resubmit Claim with correct code. In addition, Claims with codes which have been deleted will be rejected or denied.

Coding Software. Updates to [redacted] Claims processing filters, code editing software, pricers, and any edits related thereto, as a result of changes in Coded Service Identifier(s) reporting guidelines and instructions, shall take place automatically and do not require any notice, disclosure or amendment to Provider. [redacted] reserves the right to use a code editing software as reasonably required by [redacted] to ensure Claims adjudication in accordance with industry standards, including, but not limited to, determining which services are considered part of, incidental to, or inclusive of the primary procedure and ensuring medically appropriate age, gender, diagnosis, frequency, and units billed.

Modifiers. All appropriate modifiers must be submitted in accordance with Regulatory Requirements, industry standard billing guidelines and Policies. If appropriate modifiers are not submitted, Claims may be rejected or denied.

New/Expanded Service or New/Expanded Technology. In accordance with the Scope/Change in Status section of the Agreement, as of the Effective Date of this Agreement, any New/Expanded Service or New/Expanded Technology (defined below) is not reimbursable under this Agreement. Notwithstanding the foregoing, Provider may submit the following documentation to [redacted] at least sixty (60) days prior to the implementation of any New/Expanded Service or New/Expanded Technology for consideration as a reimbursable service: (1) a description of the New/Expanded Service or New/Expanded Technology; (2) Provider's proposed charge for the New/ Expanded Service or New/ Expanded Technology; (3) such other reasonable data and information required by [redacted] to evaluate the New/Expanded Service or New/Expanded Technology. In addition, [redacted] may also need to obtain approval from applicable Agency prior to [redacted] making determination that New/Expanded Service or New/Expanded Technology can be considered a reimbursable service. If [redacted] agrees that the New/Expanded Service or New/ Expanded Technology may be reimbursable under this Agreement, then [redacted] shall notify Provider, and both parties agree to negotiate in good faith, a new [redacted] Rate for the New/Expanded Service or New/Expanded Technology within sixty (60) days of [redacted] notice to Provider. If the parties are unable to reach an agreement on a new [redacted] Rate for the New/Expanded Service or New/Expanded Technology before the end of the sixty (60) day period, then such New/Expanded Service or New/Expanded Technology shall not be reimbursed by [redacted] and the Payment in Full and Hold Harmless provision of this Agreement shall apply.

a. "New/Expanded Service" shall be defined as a Health Service: (a) that Provider was not providing to Members as of the Effective Date of this Agreement and; (b) for which there is not a specific [redacted] Rate as set forth in this WCS.

b. "New/Expanded Technology" shall be defined as a technological advancement in the delivery of a Covered Service which results in a material increase to the cost of such service. New/ Expanded Technology shall not include a new device, or implant that merely represents a new model or an improved model of a device or implant used in connection with a service provided by Provider as of the Effective Date of this Agreement.

Non-Priced Codes for Covered Services. [redacted] reserves the right to establish a rate for codes that are not priced in this WCS or in the Fee Schedule(s), including but not limited to, Not Otherwise Classified Codes ("NOC"), Not Otherwise Specified ("NOS"), Miscellaneous, Individual Consideration Codes ("IC"), and By Report ("BR") (collectively "Non-Priced Codes"). [redacted] shall only reimburse Non-Priced Codes for Covered Services in the following situations: (i) the Non-Priced Code does not have a published dollar amount on the then current applicable [redacted] State or CMS Fee Schedule, (ii) the Non-Priced Code has a zero dollar amount listed, or (iii) the Non-Priced Code requires manual pricing. In such situations, such Non-Priced Code shall be reimbursed at a rate established by

[redacted] for such Covered Service. Notwithstanding the foregoing, [redacted] shall not price Non-Priced Codes that are not Covered Services under the Members Health Benefit Plan. [redacted] may require the submission of medical records, invoices, or other documentation for Claims payment consideration.

Reimbursement for [redacted] Rate Based on Eligible Charges. Notwithstanding any reimbursement amount set forth herein, Provider shall only be allowed to receive such reimbursement if such reimbursement is for an Eligible Charge. In addition, if Provider reimbursement is under one or more of the following methodologies: Capitation, Case Rate, DRG Rate, Encounter Rate, Global Case Rate, Per Diem Rate, Per Relative Value Unit (RVU), and Per Visit Rate, then individual services billed shall not be reimbursed separately, unless otherwise specified in Article IV of this WCS.

Reimbursement for Subcontractors. [redacted] shall not be liable for any reimbursement in addition to the applicable [redacted] Rate as a result of Provider's use of a subcontractor. Provider shall be solely responsible to pay subcontractors for any Health Services, and shall via written contract, contractually prohibit such subcontractors from billing, collecting or attempting to collect from [redacted] or Members. Notwithstanding the foregoing, if [redacted] has a direct contract with the subcontractor, the direct contract shall prevail over this Agreement and the subcontractor shall bill [redacted] under the direct contract for any subcontracted services, with the exception of nursing services provided for Home Infusion Therapy, or unless otherwise agreed to by the parties.

Tax Assessment and Penalties. The [redacted] Rates in this Agreement include all sales and use taxes and other taxes on Provider revenue, gross earnings, profits, income and other taxes, charges or assessments of any nature whatsoever (together with any related interest or penalties) now or hereafter imposed against or collectible by Provider with respect to Covered Services, unless otherwise required by Agency pursuant to Regulatory Requirements. Neither Provider nor [redacted] shall add any amount to or deduct any amount from the [redacted] Rates, whether on account of taxes, assessments, tax penalties or tax exemptions.

Updates to [redacted] Rate(s) Based on External Sources. Unless otherwise required by Regulatory Requirements, and notwithstanding any proprietary fee schedule(s)/rate(s)/methodologies, [redacted] shall use commercially reasonable efforts to update the [redacted] Rate(s) based on External Sources, which include but are not limited to, i) CMS Medicare fee schedule(s)/rate(s)/methodologies; ii) Medicaid or State Agency fee schedule(s)/rate(s)/methodologies; iii) vendor fee schedule(s)/rate(s)/methodologies; or iv) any other entity's published fee schedule(s)/rate(s)/methodologies (collectively "External Sources") no later than sixty (60) days after [redacted] receipt of the final fee schedule(s)/rate(s)/methodologies change from such External Sources, or on the effective date of such final fee schedule(s)/rate(s)/methodologies change, whichever is later. The effective date of such final fee schedule(s)/rate(s)/methodologies change shall be the effective date of the change as published by External Sources. Fee schedule(s)/rate(s)/methodologies will be applied on a prospective basis. Claims processed prior to the implementation of the new [redacted] Rate(s) in [redacted] payment system shall not be reprocessed, however, if reprocessing is required by Regulatory Requirements, and such reprocessing could result in a potential under and/or over payment to a Provider, then [redacted] may reconcile the Claim adjustments to determine the remaining amount Provider owes [redacted] or that [redacted] owes to Provider. Any resultant overpayment recoveries (i.e. Provider owes [redacted] shall occur automatically without advance notification to Provider. Unless otherwise required by Regulatory Requirements, [redacted] shall not be responsible for interest payments that may be the result of a late notification by External Sources to [redacted] of fee schedule(s)/rate(s)/methodologies change.

ARTICLE III
PROVIDER TYPE

Participating Provider(s) shall be limited to performing those Covered Services for which Participating Provider(s) is credentialed and licensed to perform.

"Acute Care General Hospital" means an institution providing medical, nursing and surgical treatment for sick or injured Members, usually for a short term illness or condition.

"Ambulance Provider (Air AMB)" means air transportation by fixed wing or rotary wing equipped aircraft and used only to transport the sick and injured for the purpose of, or related to, medical treatment. Air AMB shall be licensed and operated according to Regulatory Requirements.

"Ambulance Provider (Ground AMB)" means local ground transportation by a vehicle designed, equipped, and used only to transport the sick and injured for the purpose of, or related to, medical treatment. Ground AMB shall be licensed and operated according to Regulatory Requirements.

"Ambulatory Surgical/Surgery Center (ASC)" means a free-standing facility with an organized staff of providers, which has permanent facilities and equipment for the primary purpose of performing surgical procedures on an outpatient basis and provides treatment by or under the supervision of physicians and nursing services whenever the patient is in the facility.

"Behavioral Health Facility" means a facility that provides psychiatric and/or substance abuse services usually for multiple levels of care with appropriate state licensure and quality accreditation certification. Behavioral health levels of care may include all of the following or a combination thereof – inpatient acute mental health, inpatient acute detoxification, inpatient acute substance abuse rehabilitation, substance abuse residential treatment, psychiatric residential treatment, partial hospital programs (sometimes called day treatment), and intensive outpatient programs.

"Behavioral Health Practitioner" means a licensed or certified mental health and/or substance abuse practitioner, or a group of licensed or supervised practitioners with varying specialties, who work either in an independent private practice, a group setting in one or more locations, or at an appropriately licensed clinic/facility or agency providing behavioral health and/or substance abuse Health Services.

"Community Mental Health Center (CMHC)" means an entity which provides medical and behavioral care staffed by licensed practitioners including but not limited to licensed practitioners and/or licensed or certified mental health and/or substance abuse practitioner, or a group of licensed or supervised practitioners with varying specialties, who work either in an independent private practice, a group setting in one or more locations, or at an appropriately licensed clinic/facility or agency.

"Critical Access Hospital (CAH)" means a hospital certified under a set of CMS Conditions of Participation ("CoP"), which are structured differently than the acute care general hospital by providing essential service in rural communities.

"Custodial Care/Nursing Home" means a nursing home, convalescent home, skilled nursing facility ("SNF"), care home, rest home or intermediate care facility that provides a type of residential care. It is a place of residence for people who require continual nursing care and have significant difficulty performing activities of daily living.

"Diagnostic Treatment Center" means a medical facility with one or more organized Health Services not part of an inpatient hospital facility or vocational rehabilitation center primarily engaged in providing services and facilities to out-of-hospital or ambulatory patients by or under the supervision of a physician for the prevention, diagnosis and, treatment of human disease, pain, injury, deformity or physical condition.

"Dialysis Facility" means a facility, either freestanding or within a facility, providing outpatient dialysis and other similar therapeutics.

"Federally Qualified Health Center (FQHC)" means an outpatient clinic that qualifies for a reimbursement designation from the Bureau of Primary Health Care and CMS of the United States Department of Health and Human Services.

"Free Standing Birthing Center" means a facility as designated by the applicable Agency, other than a hospital's maternity facilities or a physician's office, which provides a setting for prenatal, labor, delivery, and immediate post-partum care as well as immediate care of new born infants.

"Hearing Aid Supplier (HAS)" means a provider that sells hearing aids to improve hearing acuity in compliance with the Regulatory Requirements governing such sales, if any, of the state in which the hearing aids are sold.

"Home and Community Based Services (HCBS)" means a provider managing long-term care services. Long-term care services include, but are not limited to, assistance doing everyday tasks for older, infirmed or disabled Members who may no longer be able to do these tasks for themselves. These services provide opportunities for Members to receive services in their own home or community rather than institutions or other isolated settings.

"Home Health Agency (HHA)" means a health care provider which provides skilled nursing and other skilled services on a part time, episodic, or intermittent basis in the Member's current residence; and is responsible for supervising the delivery of such services under a Plan of Care. "Plan of Care" means the program written by the Member's attending physician, setting forth the diagnosis and the prescribed Covered Services for the Member, prescribed and approved in writing by the attending physician.

"Home Infusion Therapy Provider (HIT)" means a health care provider that is a licensed pharmacy which offers intravenous administration of drugs or other substances that require infusion to be administered, subcutaneous treatments or administered injections in a home setting when ordered by a physician or other authorized health care professional.

HIT Provider provides a wide range of services required to safely and effectively administer home infusion, nutritional therapies, specialty drugs, and disease state and care management services in a home setting. Typical therapies include but are not limited to, antibiotic therapy, total parenteral nutrition, chemotherapy and pain management. Provider offers supplies and clinical services to a Member who is under the care of a physician, or other healthcare provider. Such supplies and clinical services are provided in an integrated manner under a plan established and periodically reviewed by the ordering physician or other healthcare provider. Routine supplies, as defined by CMS, are included in these services.

"Hospice Services" means Covered Services designed to give supportive care to Members in the final phase of a terminal illness. Services include, but are not limited to, Routine Home Care Day, Continuous Home Care Day, Inpatient Respite Care Day and General Inpatient Care Day.

1. Routine Home Care Day – means Covered Services for a day on which a Member who has elected to receive hospice care at current residence and is not receiving continuous care.

2. Continuous Home Care Day – means Covered Services for a day on which a Member who has elected hospice care is at home and receives hospice care consisting predominately of nursing care on a continuous basis at home. A continuous home care day is only furnished during brief periods of crisis, and only as necessary to maintain the terminally ill patient at home with a minimum of eight (8) hours of care being furnished on a particular day to qualify as a continuous home care day.

3. Inpatient Respite Care Day – means Covered Services for a day on which a Member who has elected Hospice care receives services in an inpatient facility (skilled nursing facility, hospital or inpatient hospice house) on a short-term basis when necessary to relieve family members or others caring for the Member, for respite.

4. General Inpatient Care Day – means Covered Services for a day on which the Member who has elected Hospice care receives inpatient services for pain control or acute or chronic symptom management which cannot be managed in other settings.

"Independent Laboratory (LAB)" means an entity that provides Health Services involving the procurement, transportation, testing (which includes clinical and anatomic/surgical pathology), reporting of specimens and consulting services provided by the LAB. LAB does not include providers of laboratory services rendered in connection with an inpatient service, outpatient surgery, observation room stay and pre-surgery testing.

Provider must meet and comply with the following participation criteria. The criteria must be met upon review of initial application and upon periodic review thereafter. If any of the criteria required below has expired during the periodic review, Provider agrees to submit updated documents upon request. Review of these documents will be conducted by [redacted] on a periodic basis.

Licensing and Approval

The Provider shall:

Maintain a current unrestricted Certificate of Accreditation under the Clinical Laboratory Improvement Amendment (CLIA); and

Be a participating provider of laboratory services with Medicare and Medicaid;

Maintain current professional and business licenses, permits, and certifications in good standing on all professional staff members that may be called upon to deliver services in accordance with the Agreement.

Governance, Administration, and Management

The Provider shall:

Have a governing body or clearly designated individuals, including a Medical Director, who are legally responsible for the conduct and actions of all individuals providing LAB services; and

Minimum Performance Standards.

Provider must meet and comply with the minimum performance standards as set forth below:

Provider will provide reference specimen pickup and results delivery to ordering physicians on a daily basis Monday through Friday, except holidays. Arrangements for Saturday service shall be made available as mutually agreed upon between the Provider and the ordering physician. Provider will make best efforts to pick up specimens on Saturday.

Provider agrees to submit to the ordering physician who has authorized the LAB service a report of the results of such service within one (1) working day from receipt of the specimen except, when due to the nature of the service, a longer time is required (e.g. a bacterial culture requiring several days to grow) or when the service is classified as STAT.

Ninety-five percent (95%) of STAT results will be submitted to the ordering physician within two (2) hours of specimen receipt in the testing laboratory. Such reports may initially be given verbally; provided, however, that a written report is submitted within three (3) working days following the performance of the Covered Service. Results shall be reported in the Provider's standard format.

Provider must subscribe to at least one commercial quality control program per testing category.

Provider shall ensure that no more than five percent (5%) of the tests that the Provider performs need to be re-run due to false findings, contamination, corrected or amended results. [redacted] may request that Provider submit a summary report of the results of such testing, including the rate of false positives and false negatives on a semi-annual basis.

Provider will conduct on-going patient and physician satisfaction surveys and will report results to [redacted] on a routine annual basis or as otherwise requested.

All complaints submitted to Provider by [redacted] must be appropriately researched and findings reported to [redacted] within five (5) working days of the day the Provider was notified by [redacted] of the complaint. Notwithstanding the foregoing, all regulatory complaints submitted to Provider by [redacted] must be appropriately researched and findings reported to [redacted] within the timeframe requested by [redacted]

Provider shall supply, at no additional charge, Participating Providers with test request forms which Provider requires to be completed when requesting services. Provider shall also furnish containers, mailers, and supplies as are reasonably necessary for collecting and submitting specimens to Provider at no expense to the referring physician. Provider will perform any necessary repeat tests resulting from Provider's improper handling and/or processing of specimens and notify the referring physician, at no additional charge.

Provider shall conduct initial and ongoing training and educational services to Participating Providers. Such training will include communication of laboratory policies and procedures, as well as the provision of a directory of laboratory services, which lists specimen requirements for each test and instructions for the proper handling and maintenance to ensure specimen integrity;

Provider shall deliver a report of the results of PAP laboratory tests to the ordering Participating Provider within seven (7) calendar days from the date Provider picks up the specimen.

Unless otherwise directed by [redacted] 1) Provider agrees to submit Claims to [redacted] for LAB services only when a provider with whom the Member has an established provider-patient relationship has ordered such LAB services and; 2) LAB services generated through Provider’s subcontractors, used solely for the purposes of creating orders for lab testing, are not eligible for reimbursement under this Agreement.

"Independent Practice Association (IPA)" means a legal entity organized and operated on behalf of individual participating medical professionals for the primary purpose of collectively entering into contracts to provide Health Services to Members.

"Indian Health Services Unit" means a provider who provides comprehensive health services for American Indians and Alaska Natives who are members of federally recognized Tribes across the United States.

"Intellectual Disability Services" means services to treat a disability characterized by significant limitations in both intellectual functioning and in adaptive behavior, which covers many everyday social and practical skills.

"Developmental Disability Service" means services to treat a severe, lifelong disability that substantially limits the functioning ability in three or more life activities, such as self-care, receptive and expressive language, learning, mobility, self-direction, independent living, and employability.

"Intermediate Care Facility (ICF)" means a facility for Members with Intellectual Disability which is an optional Medicaid benefit that enables states to provide comprehensive and individualized health care and rehabilitation services to Member to promote their functional status and independence.

"Long Term Acute Care (LTAC)" means a hospital specializing in treating patients requiring extended hospitalization.

"Long Term Services and Support (LTSS)" means a spectrum of health and social services that support Members with disabilities who need help with daily living tasks.

"Durable Medical Equipment (DME)" shall mean items prescribed by a provider which can withstand repeated use; are primarily used to serve a medical purpose; are generally not useful to a person in the absence of illness, injury, or disease; and are appropriate for use for activities of daily living.

"Orthotics" shall mean devices prescribed by a provider that are rigid or semi-rigid which support, restore or protect body function and restrict or eliminate motion of a weak or diseased body part.

"Prosthetics" means appliances prescribed by a provider that replace all or part of a body organ (including contiguous tissue), or replace all or part of the function of a permanently inoperative, absent or malfunctioning body part.

"Supplies" shall mean medical items prescribed by a physician that need replacement on a frequent basis.

"Methadone Treatment Provider" means a provider who offers a comprehensive treatment program which involves the long-term prescribing of methadone as an alternative to the opioid on which the Member was dependent.

Central to methadone treatment is the provision of counseling, case management and other medical and psychosocial services. Provider must have a dispensing unit, counseling offices, examining rooms and an administrative area. In addition to dispensing medication, Provider must also provide counseling and other medical services. At all times during the term of this Agreement, Provider agrees to maintain certification by the Substance Abuse and Mental Health Services Administration (SAMHSA).

"Nursing Home" means a public or private residential facility providing a high level of long-term personal and nursing care for persons (such as the aged or the chronically ill) who are unable to care for themselves properly.

"Personal Care Assistant (PCA)" means a health care provider which provides services, including personal care, household duties and health-related tasks, which are available from a licensed home care services agency, certified home health agency or homemaker agency to accommodate long-term chronic or maintenance health care.

"Physical Therapy (PT)" means corrective rehabilitation provided by licensed practitioners through the use of physical, chemical and other properties of heat, light, water, electricity, sound, massage and active, passive and resistive exercise. Physical therapist assistants (“PTA”s) provide physical therapist services under the direction and supervision of a physical therapist. PTAs implement components of patient care, obtain data related to the treatments provided, and collaborate with the physical therapist to modify care as necessary.

"Occupational Therapy (OT)" means the development of adaptive skills, increased performance capacity, and those factors that may impede or restrict ability to function provided by licensed practitioners. Occupational therapy assistants (“OTA”s) work under the guidance of an occupational therapist in various practice areas and settings. While the occupational therapist evaluates and develops treatment plans for clients/patients, the OTA puts those plans into action, teaching individuals how to overcome the challenges of performing daily activities because of an injury, illness, or disability.

"Speech Therapy (ST)" means the evaluation and treatment of disorders that result in impaired or ineffective communication provided by licensed practitioners.

"Physician Hospital Organization (PHO)" means a separate legal entity formed by one or more physicians and one or more hospitals whose objective it is to provide and arrange for Health Services to Members.

"Primary Care Physician" or "Primary Care Provider" ("PCP") means a Participating Provider who (a) is primarily responsible for supervising, managing and coordinating the overall health care needs of Members; (b) is credentialed in accordance with this Agreement; (c) provides Primary Care Services; and (d) practices in the medical specialty areas of general practice, internal medicine, pediatrics, family medicine, or such other medical specialty areas as are specified to provide Primary Care Services in an applicable Government Contract.

To the extent mandated by Regulatory Requirements, Provider shall ensure that Members have access to 24 hour-per-day, 7 day-per-week urgent and Emergency Services, as defined in the WCS.

Unless otherwise required under Regulatory Requirements, PCP shall provide Covered Services or make arrangements for the provision of Covered Services to Members on a twenty-four (24) hour per day, seven (7) day a week basis to assure availability, adequacy, and continuity of care to Members. If Provider is unable to provide Covered Services, Provider will arrange for another Participating Provider to cover Provider's patients in accordance with Policies. Provider and any Primary Care Providers employed by or under contract with Provider may arrange for Covered Services to Members to be performed by a Specialty Physician only in accordance with Policies.

Primary Care Services means (a) those Covered Services provided to a Member involving primary medical care, including, but not limited to, the Covered Services specifically identified as primary care services in an applicable Government Contract, and (b) the supervision and coordination of the delivery of these Covered Services to a Member.

"Private Duty Nursing (PDN)" means the provision of medically necessary, complex skilled nursing care in the home by a Registered Nurse (RN) or a Licensed Practical Nurse (LPN).

The purpose of private duty nursing is to assess, monitor and provide skilled nursing care in the home on an hourly basis; to assist in the transition of care from a more acute setting to home; and to teach competent caregivers the assumption of this care when the condition of the Member is stabilized. The length and duration of private duty nursing services is intermittent and temporary in nature and not intended to be provided on a permanent ongoing basis. The private duty nurse cannot be a member of the Member's immediate family or anyone living in the home.

"Psychiatric Medical Institute for Children (PMIC)" means a facility licensed to provide in-patient psychiatric treatment to Members under the age of 21.

"Radiology Imaging Center" means a free standing facility which has equipment for diagnostic imaging services such as X-rays, computerized axial tomography ("CAT") scans, and magnetic resonance imaging ("MRI").

"Rehabilitation Facility" means a facility which is licensed to provide comprehensive rehabilitation services, including but not limited to, therapy and training for rehabilitation, occupational therapy, physical therapy and speech therapy to Members for the alleviation of disabling effects of illness or intended to achieve the goal of maximizing the self-sufficiency of the Member.

"Residential Treatment Facility (RTF)" means an inpatient psychiatric or substance abuse facility that provides psychiatric, substance abuse and other therapeutic and clinically informed services to Members whose immediate treatment needs require a structured twenty four (24) hour residential setting that provides all required services (including schooling) on site. Services provided include, but are not limited to, multi-disciplinary evaluation, medication management, individual, family and group therapy, parent guidance, substance abuse education/counseling (when indicated) and other support services including on site education (where appropriate), designed to assist the person to achieve success in a less restrictive setting.

"Respite Care" means the temporary care of a dependent elderly, ill, or handicapped person, providing relief for their usual caregivers.

"Rural Health Clinic (RHC)" means a clinic that is located in an area that is designated both by the U.S. Census Bureau as rural and by the Secretary of Health and Human Services as medically underserved. RHCs provide primarily outpatient services that are typically furnished in a physician's office.

"School Based Health Centers" means a model of health care services provided to youth in a convenient and accessible environment consisting of onsite school-based health care delivery by an interdisciplinary team of health professionals, which can include primary care and mental health clinicians.

"Skilled Nursing Facility" means a facility which mainly provides inpatient skilled nursing and related services to Members requiring convalescent and rehabilitation care given by or under the supervision of a qualified/certified practitioner as licensed in the state, following a hospitalization, for a limited period.

"Specialty Physician Group" means one or more licensed or certified medical practitioners who have specialized education, training or experience in accordance with the Regulatory Requirements of the state in which Health Services are rendered.

If Provider is furnishing Specialty Physician services under this Agreement, Provider, and the Specialty Physician(s) employed by or under contract with Provider, shall accept as patients all Members and may arrange for Covered Services to Members to be performed by a Specialty Physician only in accordance with Policies.

"Specialty Physician Individual" means a licensed or certified medical practitioner who has specialized education, training or experience in accordance with the Regulatory Requirements of the state in which Health Services are rendered.

If Provider is furnishing Specialty Physician services under this Agreement, Provider, and the Specialty Physician(s) employed by or under contract with Provider, shall accept as patients all Members and may arrange for Covered Services to Members to be performed by a Specialty Physician only in accordance with Policies.

"Specialty Provider Group (Non-MD or DO)" means one or more licensed or certified medical practitioner(s) who has specialized education, training or experience in accordance with the Regulatory Requirements of the state in which Covered Services are rendered.

"Specialty Provider Individual (Non-MD or DO)" means a licensed or certified medical practitioner who has specialized education, training or experience in accordance with the Regulatory Requirements of the state in which Health Services are rendered.

"Subacute Care" means a level of care needed by a Member who does not require hospital acute care, but who requires more intensive skilled nursing care than is provided to the majority of Members in a Skilled Nursing Facility.

"Urgent Care Center (UCC)" means an entity which provides treatment and diagnosis of conditions that require prompt attention in order to prevent serious deterioration to the Member's health, but would not generally be considered to require treatment in an emergency room.

ARTICLE IV
SPECIFIC REIMBURSEMENT TERMS

MEDICARE ADVANTAGE

For Covered Services furnished by or on behalf of Provider for a Member enrolled in a Medicare Advantage Network, Provider agrees to accept an amount that is the lesser of Eligible Charges or the [redacted] Medicare Advantage Rate, minus applicable Cost Shares, and modified before payment as described below. Provider agrees that this amount, plus applicable Cost Shares, is full compensation for Covered Services.

Fee Schedule: The "[redacted] Medicare Advantage Rate" is the amount calculated based on the rate or methodology stated below for each service, adjusted as described in the notes, and multiplied by the stated percentage.

The [redacted] Medicare Advantage Rate shall be calculated based on the [Specific Medicare Fee Schedule] multiplied by [Percent of [redacted] Medicare].

When determining the amount payable to Provider, any reimbursement terms in this Agreement that are based, in whole or in part, on Medicare rates, pricing, fee schedules, or methodologies published or established by CMS, shall refer to the per claim payment amounts that CMS and a Medicare beneficiary would directly pay to Provider for the same items or services under original Medicare Part A or Part B. The amount payable to Provider shall not include any bonus payment or settlement amount paid to Provider by CMS outside of the Medicare per claim payment process, unless otherwise set forth in the Medicare Advantage reimbursement terms of this Agreement. Unless [redacted] notifies Provider otherwise, in the event CMS changes payment to Provider due to a CMS directive, Act of Congress, Executive Order, other governmental pronouncement, or Regulatory Requirement, the amount payable to Provider hereunder will automatically be changed as soon as reasonably practicable, as described herein, in the amount specified by CMS as a result of such directive or change in law, or in the absence of such specification, in the same percentage amount as payment is changed by CMS to Provider.

[redacted] shall not compensate Provider for the bad debts of its Medicare Advantage members.

[redacted] and Provider shall consider Medicare interim amounts, including but not limited to, indirect medical education, disproportionate share, outliers, per diems, percent of charge, and all-inclusive rates, as final and [redacted] shall not adjust Provider's compensation through a settlement, even if Medicare adjusts its compensation to Provider based on a settlement.

[redacted] shall compensate Provider using the relevant payment system logic and data (for example: calculations, payment groupings, or federal and provider-specific factors) that are available in [redacted] systems at the time [redacted] processes the Provider's Claim. [redacted] shall not retroactively adjust Provider's compensation for previously processed Claims to reconcile any difference with the payment system logic and data being used by Medicare on the same processing date for the same date of service. In addition, [redacted] shall not retroactively adjust Provider's compensation for previously processed claims to reflect Medicare's retroactive updates or changes to payment system logic and data. Provider shall not request adjustments solely based on these differences, updates, or changes.

MEDICAID

Fee Schedule:
For purposes of determining the [redacted] Rate, the total reimbursement amount that Provider and [redacted] have agreed upon for the applicable provider type(s) for Covered Services provided under this Agreement shall be [(XX%)] of the [[redacted] Professional Provider Market Master Fee Schedule] in effect on the date of service.

The parties acknowledge and agree that the [[redacted] Professional Provider Market Master Fee Schedule] is subject to modification by [redacted] at any time during the term of this Agreement and will be applied on a prospective basis.

In accordance with [redacted] Program Contractor Risk Agreement (CRA) section A.2.13.2.2, [redacted] shall not reimburse providers based on automatic escalators or linkages to other methodologies that escalate such as current Medicare rates or inflation indexes unless otherwise allowed by [redacted]

Medicaid Affiliate Services. Provider acknowledges that [redacted] is affiliated with health plans that offer similar benefits under similar programs as the programs covered hereunder ("Medicaid Affiliates"). The parties acknowledge that Provider is not a Participating Provider in Medicaid Affiliate's Network for purposes of rendering services to Medicaid Members. However, in the event Provider treats a Medicaid Member of a Medicaid Affiliate, subject to Regulatory Requirements, Provider shall accept as payment in full the rates established by the Medicaid Affiliate's state program governing care to Medicaid Members. Such services must be Medicaid Covered Services under the Medicaid Affiliate's state program, and shall require prior authorization, except for Emergency Services and services for which a Medicaid Member is entitled to self-refer. Upon request, [redacted] shall coordinate and provide information as necessary between Provider and Medicaid Affiliate for services rendered to Medicaid Member.

Reimbursement Specific to Provider Type

The following will be reimbursed for facility services only: Acute Care Hospital, ASC, Behavioral Health Facility, Free Standing Birthing Center, Rehabilitation Facility and SNF. Professional services are excluded.

Ambulance Provider Air and/or Ground shall be reimbursed in accordance with Regulatory Requirements for the applicable methodology based on the referenced fee schedule. If such reimbursement is based on an [redacted] Rate, the applicable state methodology on which such fee schedule is based, shall be used to determine the appropriate level of reimbursement. Reimbursement includes wait time, extra attendant, parking fees, tolls, and all supplies, oxygen, equipment, medicines and solutions provided during ambulance service.

Hospice reimbursement is inclusive of skilled nursing, home health aide, medical social worker services, dietary, pastoral, bereavement counseling, DME, medical supplies and administration of medication.

LAB services not specified on the Reference Laboratory Fee Schedule are not reimbursable.

Specialty Provider Individual and/or group (Non-MD or DO) shall be reimbursed in accordance with Regulatory Requirements for the applicable methodology based on the referenced fee schedule. If such reimbursement is based on an [redacted] proprietary fee schedule, the applicable state methodology on which such fee schedule is based, shall be used to determine the appropriate level of reimbursement.

"Ambulatory Patient Group" ("APG") means the [redacted] Rate that is a fixed reimbursement to a facility for Outpatient Services and which incorporates data regarding the reason for the visit and patient data.

"Ambulatory Payment Classification" ("APC") or its successor shall have the meaning set forth in the Medicare law and CMS regulations and guidance.

"[redacted] DMEPOS and PEN Fee Schedule" means the applicable [redacted] DMEPOS and PEN Fee Schedule for the market(s) and program(s) covered by the Agreement. The parties acknowledge and agree that the [redacted] DMEPOS and PEN Fee Schedule is subject to modification by [redacted] at any time during the term of the Agreement. [redacted] DMEPOS and PEN Fee Schedule and/or rate changes will be applied on a prospective basis.

"[redacted] Professional Provider Market Master Fee Schedule(s)/ Rate(s)/ Methodologies" means the proprietary rate that may be based on, but is not limited to, the applicable [redacted] Professional Provider Market Master Fee Schedule(s)/ Rate(s)/ Methodologies, CMS and/or Medicare Fee Schedule(s)/ Rate(s)/ Methodologies, or the Fee Schedule(s)/ Rate(s)/ Methodologies developed by [redacted] in accordance with industry standards.

"[redacted] Reference Laboratory Fee Schedule" means the [redacted] Rate that is the [redacted] Reference Laboratory Fee Schedule that is based on the Medicare Fee Schedule and may contain additional CPT/HCPCS codes. [redacted] Reference Laboratory Fee Schedule and/or rate changes will be applied on a prospective basis.

"CMS Outpatient Prospective Payment System" ("OPPS") shall have the meaning set forth in Medicare law and CMS regulations and guidance.

"Medical Care Management Rate" means the amount paid by [redacted] to Provider on a per member per month basis for facilitation of collaborative programs meant to manage medical/social/mental health conditions more effectively.

"Medicare Fee Schedule" means the applicable Medicare Fee Schedule for the provider type(s) identified herein, including payment conversion factor, where applicable, and in effect on the date of the service is initiated to Members. Medicare Fee Schedule and/or rate changes will be applied on a prospective basis.

"Medicare LUPA National Base Rate" means the Medicare LUPA ("Low Utilization Payment Adjustment") National Base rate in effect as of the date of service for the market(s) and program(s) covered by the Agreement at the time the Covered Services are initiated to the Member. Medicare LUPA National Base Rate changes will be applied on a prospective basis.

"Medicare Part B Drug Average Sales Price ("ASP") Fee Schedule" means the Medicare Part B Drug Average Sales Price ("ASP") Fee Schedule (or successor) in effect as of the date of service for the market(s) and programs covered by the Agreement at the time the Covered Services is initiated to the Member. Medicare Part B Drug Average Sales Price ("ASP") Fee Schedule and/or rate changes will be applied on a prospective basis.

"Tennessee Medicaid Rate(s)/Fee Schedule(s)/Methodologies" means the Tennessee Medicaid Rate(s)/Fee Schedule(s)/ in effect on the date of service for the provider type(s)/service(s) identified herein for the applicable Medicaid Program(s).