Introduced by _____ Council Bill No. _____R 55-14_____

A RESOLUTION

authorizing a participating provider agreement with Missouri Care, Inc. (a WellCare Company) to allow for reimbursement of approved clinical services provided to WellCare participants.

BE IT RESOLVED BY THE COUNCIL OF THE CITY OF COLUMBIA, MISSOURI, AS FOLLOWS:

SECTION 1. The City Manager is hereby authorized to execute a participating provider agreement with Missouri Care, Inc. (a WellCare Company) to allow for reimbursement of approved clinical services provided to WellCare participants. The form and content of the agreement shall be substantially as set forth in "Exhibit A" attached hereto and made a part hereof.

ADOPTED this _____ day of _____, 2014.

ATTEST:

_____ _____

City Clerk Mayor and Presiding Officer

APPROVED AS TO FORM:

_____

City Counselor

PARTICIPATING PROVIDER AGREEMENT
Physician / Professional

THIS PARTICIPATING PROVIDER AGREEMENT ("Agreement") is made and entered into as of the Effective Date (as defined herein) by and between Missouri Care, Incorporated ("Health Plan") and the City of Columbia, MO on behalf of its Department of Public Health and Human Services ("Provider" or "Physician").

WHEREAS, Health Plan is (or is seeking to become) a Qualified Health Plan in the Individual Market on one or more State Health Insurance Exchanges;

WHEREAS, Health Plan issues (or is seeking a license permitting it to issue) insurance products for Essential Health Benefits and related health benefits, and seeks to include providers in its networks for such Products;

WHEREAS, Provider provides health care items and professional physician services to the general public; and

WHEREAS, Health Plan and Provider desire to enter into this Agreement whereby Provider will provide health care items and professional physician services to Qualified Individuals enrolled in Health Plan's Products in exchange for payments from Health Plan, all subject to and in accordance with the terms of this Agreement;

NOW THEREFORE, the parties agree as follows:

1. **Definitions**. As used in this Agreement:

1.1. "**Accreditation Standards**" means the standards Health Plan is required to adhere to in order to acquire or maintain health plan accreditation from the National Committee for Quality Assurance ("NCQA") or the Utilization Review Accreditation Commission ("URAC").

1.2. "**Affiliates**" means, with respect to a particular entity, another entity that directly, or indirectly through one or more intermediaries, controls, is controlled by or is under common control with, the entity. An entity "**controls**" an entity in which it has the power to vote, directly or indirectly, 50 percent or more of the voting interests in such entity or in the case of a partnership if it is a general partner, or the power to direct or cause direction of management and policies of such entity, whether through the ownership of voting shares, by contract or otherwise.

1.3. "**Affordable Care Act**" means the federal Patient Protection and Affordable Care Act, (P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152).

1.4. "**Benefit Plan**" means a health benefit policy or other health benefit contract or coverage document issued or administered by Health Plan. Benefit Plans and their designs are subject to change periodically.

1.5. "**Claim**" means a bill for services, a line item of service, or all services for one recipient within a bill on an industry standard form.

1.6. "**Clean Claim**" means a claim that has no defect, impropriety, or lack of any required substantiating documentation that prevents timely payment and that can be processed without obtaining additional information from the provider or a third party. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for Medical Necessity.

1.7. "**CMS**" means the Centers for Medicare and Medicaid Services.

1.8. "**Cost Sharing**" means any expenditure required by or on behalf of a Member and includes deductibles, coinsurance, copayments or similar charges, but excludes premiums, balance billing amounts for non-network providers, and spending for non-Covered Services. [45 CFR 155.20]

1.9. "**Covered Services**" means Medically Necessary services covered under a Health Plan Benefit Plan, including Essential Health Benefits and Preventive Health Services. [45 CFR 147.150]

1.10. "**Credentialing Criteria**" means Health Plan's criteria for the credentialing or re-credentialing of Providers.

1.11. "**Dependent**" means a Member's lawful Spouse or a Member's Eligible Child. As used in this definition, "**Spouse**" means a lawful wife or husband or, where required by applicable Laws, domestic partners. As used in this definition, "**Eligible Child**" means a Member's or a Member's Spouse's Child, if that Child is less than 26 years of age. As used in this definition, "**Child**" means: (a) a natural child; (b) a legally adopted child; (c) a child placed with a Member for adoption; (d) a child for whom legal guardianship has been awarded to the Member or the Member's spouse; or (e) an unmarried child from the first of the month following the month in which the child turns age 26 until the end of the calendar year in which the child turns 30 years of age, and who is a resident of the State in which the Member's policy was issued or a full-time or part-time student, and is not provided coverage as a named member under any other group or individual health benefit plan, or is not entitled to benefits under Title XVIII of the Social Security Act.

1.12. "**Effective Date**" means the effective date of this Agreement as selected by Health Plan and shown on the Signature Page.

1.13. "**Emergency Medical Condition**" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (ii) serious impairment to bodily functions; and (iii) serious dysfunction of any bodily organ or part. [45 CFR 147.138]

1.14. "**Emergency Services**" means, with respect to an Emergency Medical Condition, (a) a medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition, and (b) such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, to stabilize the patient. [45 CFR 147.138]

1.14.1. "**Stabilize**" or "**Stabilization**" means, with respect to an Emergency Medical Condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to a pregnant woman who is having contractions, to deliver (including the placenta). [42 USC 1395dd]

1.15. "**Essential Community Providers**" means providers that serve predominantly low-income, medically underserved individuals, including providers that meet the criteria of 45 CFR 156.235.

1.16. "**Essential Health Benefits**" means the Covered Services and associated limits of a health insurance product offered by Health Plan as defined by 42 USC 18022(b)(2) and shall include the minimum statutory standards required under Laws, including, where applicable: (a) ambulatory patient services; (b) emergency services; (c) hospitalization; (d) maternity and newborn care; (e) mental health and substance use disorder services, including behavioral health treatment; (f) prescription drugs; (g) rehabilitative and habilitative services and devices; (h) laboratory services; (i) preventive and wellness services and chronic disease management; and (j) pediatric services, including oral and vision care. [45 CFR 156.110(a)]

1.17. "**Exchange**" or "**Health Insurance Exchange**" means a Federally Facilitated Exchange, a State Partnership Exchange or a State Based Exchange, as defined in the applicable Program Attachment, and established pursuant to section 18031 of the Affordable Care Act or State Laws.

1.18. "**Governmental Authority**" means the United States of America, the States, or any department or agency thereof having jurisdiction over Health Plan, a Provider or their respective Affiliates,

employees, subcontractors or agents.

1.19. "**HHS**" means the U.S. Department of Health and Human Services.

1.20. "**HIPAA**" means the federal Health Insurance Portability and Accountability Act of 1996, and rules and regulations pursuant thereto.

1.21. "**Individual Market**" means the market for health insurance coverage offered to individuals other than in connection with a group health plan. As used in this definition, **"Group Health Plan"** means an employee welfare benefit plan as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974 to the extent that such group health plan provides medical care, and including any item or service paid for as medical care to an employee or the employee's dependent, as defined under the terms of the plan, directly or through insurance, reimbursement or otherwise, but not including excepted benefits.

1.22. "**Laws**" means any and all applicable laws, rules, regulations, statutes, orders, standards, guidance and instructions of any Governmental Authority, as adopted, amended, or issued from time to time, including (a) the Social Security Act, including Titles XVIII ("Medicare"), XIX ("Medicaid") and XXI (State Children's Health Insurance Program or "CHIP"), (b) the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), (c) federal and state privacy laws other than HIPAA, (d) federal and state laws regarding patients' advance directives, (e) state laws and regulations governing the business of insurance, (f) state laws and regulations governing third party administrators or utilization review agents, (g) state laws and regulations governing the provision of health care services, and (h) federal and state laws regarding the establishment and operation of Health Insurance Exchanges.

1.23. "**Medically Necessary**" or "**Medical Necessity**" means, with respect to health care items or services, items and services that are (i) necessary to protect life, prevent significant illness or significant disability or to alleviate severe pain, (ii) individualized, specific and consistent with symptoms or confirm diagnosis of the illness or injury under treatment and not in excess of the Member's needs, (iii) consistent with generally accepted professional medical standards and not experimental or investigational, (iv) reflective of the level of service that can be provided safely and for which no equally effective and more conservative or less costly treatment is available statewide, (v) provided in a manner not primarily intended for the convenience of the Member, the Member's caretaker or the health care provider, and (vi) not custodial care. For health care items and services provided in a hospital on an inpatient basis, "**Medically Necessary**" or "**Medical Necessity**" also means that such items and services cannot, consistent with the provisions of appropriate medical care, be effectively provided more economically on an outpatient basis or in an inpatient facility of a different type. The fact that a health care provider has prescribed, recommended or approved health care items or services does not, in itself, make such items or services Medically Necessary or a Medical Necessity.

1.24. "**Member**" means a Qualified Individual properly enrolled in a Health Plan Exchange Benefit Plan and eligible to receive Covered Services at the time such services are rendered, and may include the Member's Dependent.

1.25. "**Participating Provider**" means an individual or entity that has entered into an agreement with Health Plan or a Health Plan contractor to provide or arrange for the provision of Covered Services to Members.

1.26. "**Policies and Procedures**" means Health Plan's rules, protocols, principles and guidelines.

1.27. "**Preventive Health Services**" shall be defined by 45 CFR 147.130 and Health Plan may use reasonable medical management techniques to determine the frequency, method, treatment, or setting of Preventive Health Services to the extent not specified in the recommendations or guidelines specified in 45 CFR 147.130.

1.28. "**Primary Care Physician**" or "**PCP**" means an individual practitioner in family medicine, general medicine, internal medicine, pediatrics, or obstetrics and gynecology, who provides primary care

services to patients and designated by Health Plan or the Member as the Member's Primary Care Physician. [42 USC 300gg-19a]

1.29. "**Primary Care Services**" means health care items or services available from Primary Care Providers within the scope of their medical or professional licenses or certifications, and shall include primary care items and services required by the Provider Manual or Program Requirements, which may include (i) assuring the timeliness of urgent, emergent, sick and preventive care to Members; (ii) conducting initial health assessments of new Members when such assessments are Covered Services under the applicable Benefit Plan; (iii) informing Members of specific health care needs that require follow up; (iv) instructing Members on measures they may take to promote their own health; (v) providing the coordination necessary for the referral of Members to specialists; or (vi) monitoring and follow-up of care provided by other providers for diagnosis and treatment.

1.30. "**Product**" means a Health Plan Benefit Plan.

1.31. "**Program**" means a commercial insurance program, including a program created under Laws regarding commercial Health Insurance Exchanges.

1.32. "**Program Attachment**" means an attachment to this Agreement describing the terms and conditions of a Provider's participation in a Benefit Plan under a Program.

1.33. "**Program Requirements**" means Health Plan's or a Governmental Authority's requirements applicable to Health Plan's Products offered on commercial Health Insurance Exchanges, including network adequacy, Essential Health Benefits, and Essential Community Provider standards.

1.34. "**Provider**" means (a) the provider listed in the first paragraph of this Agreement ("**Contracted Provider**"), or (b) other individual or entity that is subject to an employment arrangement or direct or indirect subcontract with Contracted Provider to provide or arrange for the provision of Covered Services to Members under this Agreement.

1.35. "**Provider Manual**" means Health Plan's provider manual and quick reference guides, available on Health Plan's provider website, which set forth Health Plan's administrative requirements for providers in Health Plan's participating provider networks for a Product.

1.36. "**Qualified Health Plan**" or "**QHP**" means an issuer that has in effect a certification that its Benefit Plans meet the criteria for certification described in 42 USC 18031(c).

1.37. "**Qualified Individual**" means an individual who has been determined eligible to enroll as a Member through the Exchange in a Qualified Health Plan in the Individual Market. [45 CFR 155.20]

1.38. "**Specialist**" means an individual practitioner within the scope of a particular medical specialty.

1.39. "**Specialty Provider Services**" means health care items and services within the scope of a particular medical specialty.

1.40. "**State**" means any of the 50 United States, the District of Columbia or a U.S. territory.

2. **Scope.**

2.1. Provider shall participate as a network provider for the Health Plan Products offered on the State Health Insurance Exchange in the Individual Market as set forth in Attachment A.

2.2. Communication with Members. Providers may freely communicate with Members about their treatment, regardless of benefit coverage limitations. Medical care is the responsibility of the treating health care provider regardless of any coverage determination by Health Plan.

2.3. Carve Out Agreements. If Health Plan enters into an agreement with a third party giving

the third party financial responsibility for a subset of Covered Services, then during the term of such third party agreement, that subset of Covered Services shall be outside the scope of Covered Services contracted for under this Agreement. Examples of such "carve out" agreements are network agreements for dental, vision, hearing or transportation services.

2.4. Credentialing. Provider must meet Health Plan's Credentialing Criteria, which shall conform to applicable Laws and Accreditation Standards. Provider consents to and shall comply with Health Plan's Policies and Procedures, and Accreditation Standards, regarding credentialing or recredentialing, as set forth in this Agreement and the Provider Manual, which may include site reviews. Health Plan conducts credentialing of providers before listing them as participating in Health Plan's provider networks. If Provider provides Health Plan authorized Covered Services to a Member before successful completion of credentialing, the provision of and payment for such services shall be pursuant to Health Plan's non-participating provider rates and policies, or applicable State Laws.

2.5. Subcontractors. Provider shall only use personnel who are employed by Provider to provide Covered Services to Members under this Agreement. Provider shall not subcontract with third parties to provide Covered Services to Members under this Agreement except upon Health Plan's written consent, which consent shall be conditioned on the proposed subcontractor meeting Health Plan's Credentialing Criteria.

2.6. Delegation. Health Plan has not delegated any functions to Provider under this Agreement, unless a Delegation Addendum for an Exchange Benefit Plan is attached to this Agreement and signed by both parties.

3. **Qualified Health Plan Certification.**

3.1. QHP Requirements. During the term of this Agreement, Provider shall cooperate with Exchange rules and requirements and QHP issuer participation standards, including implementing and reporting on quality improvement strategies and reporting information on health care quality and outcomes. [45 CFR 156.200]

3.2. Decertification or Non-Renewal. In the event of revocation, suspension, decertification or non-renewal as a QHP, Health Plan shall (a) notify the Exchange in accordance with Laws; (b) notify Provider prior to the recertification process or upon notice of decertification, as applicable; (c) cover benefits for each Member through the end of the plan or benefit year or until the decertification date, as applicable; (d) provide notice of non-renewal or decertification to its QHP Members; and (e) terminate coverage of its QHP Members in accordance with 45 CFR 156.270. Provider shall cooperate with Health Plan to fulfill its data reporting obligations for the last plan or benefit year of certification. This Agreement shall terminate effective upon the later of: (a) the decertification date or (b) the end of the plan year, in the case of non-renewal.

4. **Network Adequacy.** Provider acknowledges that Health Plan must ensure that its provider networks meet state and federal network adequacy standards. [45 CFR 156.230 and 156.235] Provider shall notify Health Plan of any factors that affect Health Plan's network adequacy, including: (a) Provider's inclusion as an Essential Community Provider, if applicable; (b) number and types of providers, including providers that specialize in mental health and substance abuse services; (c) whether Provider is not accepting new patients; or (d) any other State Law requirements related to network adequacy.

5. **Provider Responsibilities**.

5.1. Covered Services. Provider shall provide Members with Covered Services that are available from Provider and that are within the scope of Provider's medical or professional licenses or certifications. Provider shall provide such Covered Services in accordance with applicable Laws, and generally accepted standards of clinical or medical practice, including nationally recognized clinical protocols and guidelines, where available. Provider shall provide Covered Services without unreasonable delay.

5.1.1. PCPs. PCPs shall arrange and coordinate the overall health care of Members,

including the provision of primary care and appropriate referral to other providers, and management of administrative functions relating to the delivery of Covered Services to Members.

5.1.2. Specialists. Specialists shall provide care in their medical specialty for Members, upon appropriate referral (where applicable).

5.2. Health Plan's Policies and Procedures. Provider shall comply with Health Plan's Policies and Procedures, including credentialing or recredentialing, utilization review, and referral procedures, as set forth in this Agreement and the Provider Manual. Provider shall cooperate with Health Plan with regard to activities that improve health care quality, including effective case management, quality reporting and documentation of care, prevention of hospital readmissions, and improving patient safety. [45 CFR 158.150] Provider shall cooperate with Health Plan designees performing administrative functions for Health Plan to the same extent that it is required to cooperate with Health Plan.

5.3. Participating Provider Application. Unless previously provided, upon delivery of this Agreement to Health Plan, Provider shall provide Health Plan with a participating provider application including current contact and billing information for Provider, its service locations covered by this Agreement, and a completed exemplar claim form.

5.4. Changes to Provider Demographics. Provider shall notify Health Plan of changes in or corrections to Health Plan's provider directory, Provider's national provider identification (NPI) numbers, name, contact persons, office or billing addresses, office hours, phone or fax numbers, or board certifications or specialties within 30 days of any changes in such information, or such other time period as required by State Laws.

5.5. Additional Notices. In addition to any other notices required under this Agreement, Provider shall give notice to Health Plan within five business days of the occurrence of any event that could reasonably be expected to impair the ability of Provider to comply with the obligations of this Agreement, including any of the following: (a) an occurrence that causes any of the representations and warranties in this Agreement made by Provider to be inaccurate; (b) Provider fails to maintain insurance as required by this Agreement; (c) Provider's license, certification or accreditation expires or is suspended or revoked; or (d) a grievance or civil legal action is filed by a Member against Provider.

6. **Provider Manual**.

6.1. The Provider Manual is available on Health Plan's provider website, and supplements and is made part of this Agreement. Provider shall comply with Health Plan's administrative requirements contained in the Provider Manual, including requirements that Provider: (a) check Member or a Member's Dependent eligibility before providing Covered Services, except in cases of Emergency Services in accordance with 42 USC 300gg-19a(b), (b) obtain prior authorizations for Covered Services, except in cases of Emergency Services in accordance with 42 USC 300gg-19a(b), or in the case of a female Member or Dependent who seeks coverage for obstetrical or gynecological care in accordance with 42 USC 300gg-19a(d), or where prior authorization is not required by the Member's Benefit Plan, (c) participate in Health Plan's utilization review and case/disease management programs and other programs designed to improve quality measure outcomes, (d) refer Members only to participating providers in Health Plan's provider network for a Product, except with Health Plan's consent, or except in the case of a female Member or Dependent who seeks coverage for obstetrical or gynecological care in accordance with 42 USC 300gg-19a(d), and (e) follow Health Plan's requirements for grievances and appeals.

6.1.1. Emergency Services. Health Plan's standards relating to Emergency Services and treatment of Emergency Medical Conditions and post-Stabilization care are set forth in the Provider Manual and shall conform to applicable Laws and Accreditation Standards. [45 CFR 147.138]

6.1.2. Obstetrical or Gynecological Care. Health Plan's standards relating to obstetrical or gynecological care and benefits for mothers and newborns are set forth in the Provider Manual and shall conform to applicable Laws and Accreditation Standards. [45 CFR 148.170 and 147.138]

6.2. Changes to Provider Manual. Health Plan shall notify Provider of changes to the Provider Manual at least 30 days in advance of such changes, unless a shorter time period is required for compliance with applicable Laws.

7. **Member Protections**.

7.1. Non-Discrimination. Providers shall not discriminate in their treatment of Members based on Members' health status, source of payment, cost of treatment, participation in Benefit Plans, race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, or genetic information.

7.2. Non-Covered Services. In each case before providing services to a Member that are not Covered Services, Provider shall (a) inform the Member of the specific services that are not Covered Services and that they will not be paid for by Health Plan, and (b) obtain the Member's written agreement to pay for such specific services after being so advised.

7.3. Member Cost Sharing. Health Plan's requirements related to Cost Sharing and information on annual limitations on Cost Sharing are set forth in the Provider Manual. [45 CFR 156.130] If payment of an amount sought in a claim is denied or reduced by Health Plan, Provider shall adjust Member Cost Sharing accordingly.

8. **Claims and Reporting**.

8.1. Submission of Claims. Provider shall submit all Clean Claims for reimbursement in a format consistent with then current HIPAA Administrative Simplification standards. All Clean Claims shall be submitted electronically. Provider shall submit Clean Claims to Health Plan within 180 days of the date the Covered Services were provided.

8.2. Electronic Remittance Advice. Provider shall register and complete the forms for Electronic Funds Transfer ("EFT") and Electronic Remittance Advice ("ERA") as soon as practicable, but no later than 30 days following the Effective Date. Health Plan shall make all payments electronically.

8.3. Overpayments. Health Plan may offset overpayments from amounts due to Provider in a manner consistent with applicable Laws. An "overpayment" is any amount that Provider receives or retains that Provider is not entitled to, including incorrect or improper amounts collected as Member Cost Sharing. This section shall survive non-renewal or termination of this Agreement.

8.4. Termination of Coverage. Health Plan may deny payment for services rendered by a Provider to a Member where the Member's coverage has been terminated in accordance with 45 CFR 155.430 or 45 CFR 156.270, subject to any applicable grace periods required under Laws.

8.5. Grace Periods for Members Receiving Advance Payment of the Premium Tax Credit. In accordance 45 CFR 156.270(d) and 45 CFR 155.430, in the event that a Member receiving advance payment of the premium tax credit, as described in 45 CFR 156.270(d), fails to timely pay the Member's premiums (the "Member Default"), Health Plan shall continue to provide the Member with coverage of services for three consecutive months following the Member Default (the "Grace Period"), if the Member has previously paid at least one full month's premium during the benefit year. During the Grace Period, Health Plan must pay all appropriate claims for services rendered to the Member in the first month of the Grace Period and may pend payment of claims for services rendered to the Member in the second and third months of the Grace Period. Health Plan shall notify Provider of the possibility for denied claims when a Member is in the second and third months of the Grace Period as required by applicable Laws.

8.6. Reporting Requirements. Health Plan may request and Provider shall provide information, data or reports, including for support of risk adjustment data validation, HEDIS reporting, and information necessary for Health Plan to comply with annual reporting requirements with respect to plan or coverage benefits and health care provider reimbursement structures within 30 days of Health Plan's request, or such other time as necessary to comply with requests from Governmental Authorities. [42 USC 300gg-17]

8.7. Utilization Management. Health Plan shall be entitled to perform continuous review of the utilization of services and facilities, costs, and concurrent or retrospective reviews of medical records for utilization management purposes or to verify that services billed to or paid for by Health Plan were Covered Services or were provided and billed correctly in accordance with this Agreement.

8.8. Retroactive Disenrollment. Members' eligibility status is subject to retroactive disenrollment. Health Plan may recoup payments for services provided to such individuals after the effective date of disenrollment even if such services were authorized by Health Plan. This section shall survive non-renewal or termination of this Agreement.

8.9. Risk Adjustment. For Products that are subject to risk adjustment, Health Plan may require Provider to submit complete and accurate risk adjustment data in a manner and timeframe established by Laws. Health Plan may impose financial penalties on Provider if Provider fails to submit complete, timely or accurate data. [45 CFR 153.610]

8.10. Value Based Purchasing. Health Plan may, upon the provision of written notice to Provider, increase the reimbursement provided under this Agreement or provide other incentives for (a) improving health outcomes through the implementation of activities that include quality reporting, effective case management, care coordination, chronic disease management, medication and care compliance initiatives, for Covered Services under the Benefit Plan; (b) the implementation of activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professionals; (c) the implementation of activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology; (d) the implementation of wellness and health promotion activities; and (e) the implementation of activities to reduce health and health care disparities, including through the use of language services, community outreach, and cultural competency trainings. [42 USC 18031]

9. **Compensation**. Health Plan shall compensate Provider as set forth in Attachment B. Provider shall accept such compensation as payment in full for Covered Services rendered to Members and all other activities of Provider under this Agreement.

10. **Compliance**.

10.1. Licenses and Permits. Provider shall secure and maintain all necessary licenses, certificates, permits, registrations, consents, approvals and authorizations that must be obtained by it to perform its obligations under this Agreement.

10.2. Ownership Information. Upon Health Plan's request, Provider shall provide information to Health Plan relating to Provider's ownership and control, business transactions, and information for persons convicted of crimes against Federal Health Care Programs as required by section 1128(a) of the Social Security Act.

10.3. Fraud, Waste or Abuse. Health Plan encourages Provider to report to Health Plan any suspected fraud, waste, or abuse by Health Plan, Provider, their respective employees or contractors, or by Members. Reports may be made anonymously to Health Plan's anti-fraud, waste, and abuse hotline at (866) 678-8355.

10.4. Certification of Provider. Provider shall, upon request of Health Plan, certify, based on its best knowledge, information and belief, that all data and other information directly or indirectly reported or submitted to Health Plan pursuant to this Agreement is accurate, complete and truthful.

10.5. Payment from Federal Health Care Programs. Provider shall not claim payment in any form, directly or indirectly, from a Federal Health Care Program for services covered under this Agreement, except where permitted by applicable Laws.

10.6. Collection of Member Cost Sharing. Provider shall (a) collect Member Cost Sharing directly from the Member as provided by the Member's health care services policy, and (b) not waive, discount or rebate any such amounts, except as permitted by and in accordance with applicable Laws.

10.7. Ineligible Persons. Provider warrants and represents as of the Effective Date and throughout the term of the Agreement, that none of it, its owners or any individual or entity it employs or has contracted with to carry out this Agreement is an Ineligible Person. "Ineligible Person" means an individual or entity who (a) is currently excluded, debarred, suspended or otherwise ineligible to participate in (i) Federal Health Care Programs, as identified in the List of Excluded Individuals/Entities maintained by the Office of Inspector General (OIG), or (ii) federal procurement or non-procurement programs, as identified in the Excluded Parties List System maintained by the General Services Administration, or (b) has been convicted of a criminal offense subject to OIG's mandatory exclusion authority for Federal Health Care Programs as described in section 1128(a) of the Social Security Act, but has not yet been excluded, debarred or otherwise declared ineligible to participate in such programs.

10.8. Audit. Health Plan shall be entitled to audit Provider with respect to compliance issues, and require Provider to address compliance issues through education, counseling or corrective action plans.

11. **Insurance**. Provider warrants and represents that Provider has and shall maintain adequate commercial general liability and professional liability (malpractice) insurance or self-insurance coverage for claims arising out of events occurring during the term of this Agreement and any post non-renewal or termination activities under this Agreement and that such insurance coverage is effective as of the Effective Date in amounts required to meet Health Plan's Credentialing Criteria and workers' compensation insurance requirements under State Laws. Upon Health Plan's request, Provider shall provide Health Plan with certificates of insurance or other evidence of coverage reflecting satisfaction of the requirements of this paragraph. Provider shall provide at least 30 days' notice to Health Plan in advance of any material modification, cancellation or termination of its insurance, unless a shorter time is required under State Laws.

12. **Proprietary Information**. In connection with this Agreement, Health Plan may disclose to Provider, directly or indirectly, information that Health Plan has taken reasonable measures to maintain as confidential and which derives independent economic value from not being generally known or readily ascertainable by the public, such as Member lists and the compensation provisions of this Agreement ("Health Plan's Proprietary Information"). Provider shall hold in confidence and not disclose or use any of Health Plan's Proprietary Information except (a) as expressly permitted under this Agreement, or (b) as required by applicable Laws, or legal or regulatory process. Provider shall provide Health Plan with notice of any disclosure required by legal or regulatory process in advance of such disclosure so that Health Plan can seek an appropriate protective order. Provider shall disclose Health Plan's Proprietary Information only in order to perform its obligations under this Agreement, and only to persons who have agreed to maintain the confidentiality of Health Plan's Proprietary Information. The requirements of this Agreement regarding Health Plan's Proprietary Information shall survive non-renewal or termination of this Agreement.

13. **Records, Access and Audit**.

13.1. Maintenance of Records. Provider shall maintain operational, financial and administrative records, contracts, books, files, data and other documentation related to the Covered Services provided to Members, Claims filed and other services and activities conducted under this Agreement ("Records") in accordance with applicable Laws, generally accepted accounting principles (as applicable) and prudent record keeping practices. Provider shall maintain all documents and other evidence necessary to verify that the data submitted in accordance with 45 CFR Part 158 complies with the definitions and criteria set forth therein, and that the Medical Loss Ratio and any rebates owing are calculated and provided in accordance with 45 CFR Part 158. [45 CFR 158.502] Provider shall maintain Records for the longer of ten years or until completion of any then ongoing audit or dispute.

13.2. Access and Audit. Health Plan shall have the right to monitor, inspect, evaluate and audit Provider related to the provision of Covered Services to Members. Provider shall provide Health Plan with

access to all Records, personnel, physical facilities, equipment and other information necessary for Health Plan or its auditors to conduct the audit. Within ten business days of Health Plan's written request for Records, or such shorter time period required for Health Plan to comply with requests of Governmental Authorities or Accreditation Standards, Provider shall compile, prepare and furnish all such Records to Health Plan in a form and format reasonably requested by Health Plan. Copies of Records shall be at no cost to Health Plan.

13.3. Access by Governmental Authorities. Provider shall allow HHS, the Comptroller General, or their designees, access and entry to Provider's premises, facilities and records, including computer and other electronic systems, to evaluate, through inspection, audit, or other means, compliance with the requirements for reporting and calculation of data submitted to HHS, and the timeliness and accuracy of rebate payments made under 45 CFR 158. To the extent that Health Plan does not control access to Provider's facilities and records, Provider is contractually obligated under this Agreement to grant said access. [45 CFR 158.501]

13.4. The requirements of this Agreement regarding Records, Access and Audit shall survive non-renewal or termination of this Agreement.

14. **Term and Termination**.

14.1. Term. The term of this Agreement shall begin on the Effective Date and continue for a period of one year. Thereafter, the term shall automatically renew for successive periods of one year each unless a party gives written notice to the other party at least 90 days prior to the expiration of the then-current term that the term shall not renew, or such other time period as required by State Laws.

14.2. Termination.

14.2.1. Termination for Cause. A party may terminate this Agreement for material breach by the other party of a term or condition of this Agreement by providing the other party at least 90 days' advance written notice specifying the nature of the breach, or such other time period as required by State Laws. This Agreement shall not terminate if, during the first 60 days of the notice period, the breaching party cures the breach to the reasonable satisfaction of the non-breaching party.

14.2.2. Termination for Convenience. Either party may terminate this Agreement, in whole or with respect to any particular Program, Benefit Plan or Provider, at any time for any reason or no reason upon 90 days' advance written notice to the other party, or such other time period as required by State Laws.

14.2.3. Immediate Termination. Health Plan may terminate this Agreement immediately upon notice to Provider, as permitted by State Laws, or upon the occurrence of any of the following: (a) Health Plan becomes aware of a situation in which Provider may cause imminent harm to a Member, (b) there has been a determination by Health Plan or a Governmental Authority of fraud by Provider, (c) there has been a determination by a State licensing board or Governmental Authority that impairs Provider's ability to operate or practice, or (d) a Governmental Authority orders Health Plan to terminate the Agreement.

14.3. Notice to Members. Upon non-renewal or termination of this Agreement, Health Plan will communicate such non-renewal or termination to Members in accordance with applicable Laws. Provider shall obtain Health Plan's prior written approval of Provider communications to Members regarding the non-renewal or termination of this Agreement; provided, however, the foregoing shall not prevent an individual health care provider from engaging in communications with a Member regarding the Member's health.

14.4. Scope of Termination. Any termination of this Agreement or a Health Insurance Exchange Product shall not impact or affect any other agreements between the parties, unless otherwise specified, including any agreements pertaining to Medicaid, Medicare or government contract products.

15. **Dispute Resolution**.

15.1. Claims and Appeal Process. Health Plan's standards and requirements related to its internal Claims and Appeals Process are set forth in the Provider Manual.

15.1.1. Medically Necessary Dispute Resolution. All claims and disputes between Health Plan and Provider related to the Medical Necessity of a Covered Service proposed by Provider shall be submitted to Health Plan's Claims and Appeals Process.

15.2. External Review Process. Health Plan's standards and requirements related to its External Review Process are set forth in the Provider Manual.

15.3. Arbitration. All claims and disputes between Health Plan and Provider arising out of or relating to this Agreement shall be resolved by binding arbitration in St. Louis, Missouri. Where applicable, Provider must exhaust available remedies under Health Plan's Claims and Appeals Process and External Review Process, before seeking any other remedy, including by timely complying with all filing and procedural requirements. Provider agrees that failure to exhaust all available remedies under Health Plan's Claims and Appeals Process or External Review Process constitutes a waiver of such claims and Provider may not seek any further remedies pursuant to the Agreement, at law, or in equity. All claims and disputes, except for claims or disputes based on fraud or abusive billing practices, must be submitted to arbitration within two years of the act or omission giving rise to the claim or dispute. The failure to initiate arbitration within the foregoing time period will constitute waiver of such claims and disputes. The parties shall not assert any claim on behalf of a class or putative class, and each party expressly waives the ability to proceed on behalf of a class or putative class, in any forum. The parties agree that an arbitrator or panel may not, and has no authority to, certify a class or conduct class based arbitration. The arbitrator or panel may not, and has no authority to, award punitive or exemplary damages, including punitive or exemplary damages permitted by any statute.

15.3.1. Procedure. The arbitration shall be conducted through the American Arbitration Association ("AAA") pursuant to the AAA Commercial Arbitration Rules then in effect, subject to the following requirements. Arbitration shall be commenced by completing and filing with AAA a Demand for Arbitration form ("Demand") setting forth a description of the dispute, the amount involved and the remedy sought, and sending notice of the Demand to the opposing party. The arbitration shall be held before a single arbitrator, unless the amount in dispute is more than $1 million, in which case it shall be held before a panel of three arbitrators. In a case with a single arbitrator, the parties shall select the arbitrator by agreement within 30 days of the date the Demand was filed, and if the parties are unable to agree on the selection of an arbitrator within such time, the parties shall follow the AAA procedure for selecting an arbitrator. In the case of a panel, each party shall select an arbitrator within 30 days of the date the Demand was filed, and the two arbitrators shall select the third arbitrator within 30 days thereafter. If the two arbitrators are unable to agree on the selection of a third arbitrator within such time, the parties shall follow the AAA procedure for selecting the third arbitrator. Discovery in any arbitration in a dispute of $1 million or less shall be limited to ten document requests (including subparts), five interrogatories (including subparts), and two depositions of three hours or less. In disputes of over $1 million, discovery shall be limited at the discretion of the panel. The decision of the arbitrator or panel shall be final and binding on the parties. The award of the arbitrator or panel may be confirmed or enforced in any court having jurisdiction. Unless the arbitrator or panel determines that the arbitration is brought in bad faith, each party shall assume its own costs related to the arbitration, including costs of subpoenas, depositions, transcripts, witness fees, and attorneys' fees. The compensation and expenses of the arbitrator and administrative fees or costs of the arbitration shall be borne equally by the parties. If the arbitrator or panel determines that the arbitration is commenced in bad faith, the arbitrator or panel shall award the responding party its attorneys' fees and costs and assess arbitration fees and costs against the party that commenced the arbitration.

15.3.2. Negotiation. Before a party initiates arbitration, the parties shall meet and confer in good faith to seek resolution of the claim or dispute ("Dispute Initiation"). If a party desires to initiate the procedures under this section, the party shall give notice ("Dispute Initiation Notice") to the other party providing a description of the nature of the dispute, the legal and factual basis for the initiating party's claim or position, including relevant documentation, and naming an individual with authority to settle the

dispute on such party's behalf. If the matter involves medical claims, Provider shall provide detailed information reasonably necessary to allow Health Plan to identify the claims including, information that identifies each claim, the date of service, the date each claim was submitted to Health Plan and the facts supporting the claim for payment. Provider shall comply with Health Plan's requests for information regarding the claims at issue within five days of such requests. Within 20 days after receipt of a Dispute Initiation Notice, the receiving party shall give a written reply ("Dispute Reply") to the initiating party providing a description of the receiving party's position in connection with the dispute, including relevant documentation, and naming an individual with the authority to settle the dispute on behalf of the receiving party. The parties shall promptly make an investigation of the dispute, and commence discussions concerning resolution of the dispute within 20 days after the date of the Dispute Reply. If a dispute has not been resolved within 60 days of the Dispute Initiation Notice, either party may submit the dispute to arbitration subject to the terms herein.

15.4. Waiver of Jury Trial. Each party hereby irrevocably and unconditionally waives, to the fullest extent it may legally and effectively do so, trial by jury in any suit, action or proceeding arising hereunder.

15.5. Injunctive or Equitable Relief. Notwithstanding anything in this Agreement, either party may bring court proceedings to seek an injunction or other equitable relief to enforce any right, duty or obligation under this Agreement.

16. **Warranties**. Each party warrants and represents, as of the Effective Date and continuously thereafter throughout the term of this Agreement, as follows:

16.1. The party is a corporation or other legally recognized entity duly incorporated or organized, validly existing and in good standing under the Laws of the State in which it is incorporated, organized or operating and it has the authority to transact business in each State in which it operates.

16.2. The party has the corporate or company power and legal authority to, and has taken all necessary corporate or other action on its part to, authorize the execution and delivery of this Agreement and the performance of its obligations hereunder.

16.3. This Agreement has been duly executed and delivered by the party, and constitutes a legal, valid, and binding agreement that is enforceable against such party in accordance with its terms, except as limited by applicable bankruptcy, reorganization, moratorium and similar Laws affecting the enforcement of creditors' rights.

16.4. The execution and delivery of this Agreement and the performance of the party's obligations hereunder do not (a) conflict with or violate any provision of the party's organizational documents or Laws, or (b) conflict with, or constitute a default under, any contractual obligation of the party.

17. **Miscellaneous**.

17.1. Governing Law. This Agreement shall be governed by and construed and enforced in accordance with the Laws of the State of Missouri, except where federal law applies, without regard to principles of conflict of Laws. Each party agrees and consents to be subject to the exclusive jurisdiction and venue of the appropriate state or federal court located in St. Louis City, Missouri in any suit, action, or proceeding seeking to enforce any provision of or based on any matter arising out of or in connection with this Agreement.

17.2. Independent Contractors. Health Plan and Provider are independent contractors. This Agreement shall not be deemed to create a partnership or joint venture, or an employment or agency relationship between the parties. Neither party has the right or authority to assume or create any obligation or responsibility on behalf of the other party. Neither party is liable for the acts of the other party.

17.3. No Solicitation. For the term of this Agreement and for one year thereafter, Provider shall

not directly or indirectly solicit any Member to join a competing health plan or induce any Member to cease doing business with Health Plan.

17.4. No Off-Shoring. No work related to this Agreement may be performed outside of the United States without Health Plan's prior written consent.

17.5. No Third Party Beneficiaries. Except as otherwise provided in this Agreement, this Agreement is not a third party beneficiary contract and no provision of this Agreement is intended to create or may be construed to create any third party beneficiary rights in any third party, including any Member.

17.6. Notices. All notices required or permitted under this Agreement must be in writing and sent by (a) hand delivery, (b) U.S. certified mail, postage prepaid, return receipt requested, (c) overnight delivery service providing proof of receipt, (d) facsimile or (e) email, to the addresses of the parties as set forth on the Signature Page. Each party may designate by notice any future or different addresses to which notices will be sent. Notices will be deemed delivered upon receipt or refusal to accept delivery. Notwithstanding the notice provisions of this Agreement, Health Plan may provide notice of changes to the Provider Manual by fax, email or by posting on the provider website.

17.7. Incorporation of Laws. All terms of this Agreement are subject to applicable Laws and Accreditation Standards. Any provision now or hereafter required to be included in this Agreement by applicable Laws or Accreditation Standards shall be deemed incorporated herein and binding upon and enforceable against the parties, regardless of whether or not the provision is expressly stated in this Agreement, and Health Plan may codify the inclusion into the Agreement of such provisions upon notice to Provider.

17.8. Amendments. Except as otherwise required by applicable Laws, any amendments to this Agreement shall be in writing and, except as otherwise set forth in this Agreement, signed by both parties. However, Health Plan may amend this Agreement upon 30 days' notice to Provider; if Provider objects to the amendment, Provider shall notify Health Plan in writing of the objection within the 30 day notice period.

17.9. Regulatory Review. The parties acknowledge that this Agreement may be subject to review by Governmental Authorities. Where Governmental Authority approval is required before the parties may begin performance of this Agreement, this Agreement shall be effective only upon receipt of the approval of the relevant Governmental Authority. The parties agree to incorporate into this Agreement any modifications required by a Governmental Authority immediately upon receipt of such modifications, or alternatively to terminate the Agreement if so directed by a Governmental Authority.

17.10. Assignment. Contracted Provider may not assign, delegate or transfer this Agreement, in whole or in part, without the prior written consent of Health Plan. Health Plan may assign this Agreement, in whole or in part, to any purchaser of the assets or successor to the operations of Health Plan or its Affiliate. As used in this section, the term "assign" or "assignment" includes a change of control of a Party by merger, consolidation, transfer, or the sale of the majority or controlling stock or other ownership interest in such Party.

17.11. Intellectual Property. The parties shall not use each other's name, symbol, logo, or service mark for any purpose without the prior written approval of the other party. However, (a) Provider may include Health Plan's Product or Benefit Plan names in listings of plans Provider participates in, and (b) Health Plan may use information about Provider in information or publications identifying providers in Health Plan's participating provider network or as required by applicable Laws. Provider shall provide comparable treatment to Health Plan as provided to other health plans with respect to marketing or the display of cards, plaques or other logos provided by Health Plan to identify providers in Health Plan's participating provider network to Members.

17.12. Severability. When possible, each provision of this Agreement shall be interpreted in such manner as to be effective, valid and enforceable under applicable Laws. If any provision of this Agreement is held to be prohibited by or invalid or unenforceable under applicable Laws, such provision

shall be ineffective only to the express extent of such prohibition, unenforceability or invalidity, without invalidating the remainder of this Agreement.

17.13. Waiver. No waiver shall be effective unless in writing and signed by the waiving party. A waiver by a party of a breach or failure to perform this Agreement shall not constitute a waiver of any subsequent breach or failure.

17.14. Entire Agreement. This Agreement, including any attachments, each of which are made a part of and incorporated into this Agreement, comprises the complete agreement between the parties and supersedes all previous agreements and understandings (whether verbal or in writing) related to the subject matter of this Agreement.

17.15. Rules of Construction. The following rules of construction apply to this Agreement: (a) the words "include" or "including" or a variant thereof shall be deemed to be without limitation; (b) the word "or" means "and/or"; (c) the word "day" means calendar day unless "business day" is used; (d) the term "business day" means Monday through Friday, except federal and state holidays; (e) all words used in this Agreement will be construed to be of such gender or number as the circumstances require; (f) references to specific statutes, regulations, rules or forms include subsequent amendments or successors to them; and (g) references to a government department or agency include any successor departments or agencies to it.

17.16. Headings. The various headings of this Agreement are provided for convenience only and shall not affect the meaning or interpretation of this Agreement or any provision of it.

17.17. Interpretation. Both parties have had the opportunity to review this Agreement with legal counsel, and any ambiguity found in this Agreement shall not be construed in a party's favor on the basis that the other party drafted the provision containing the ambiguity.

17.18. Survival. Any provision of this Agreement that requires or reasonably contemplates the performance or existence of obligations by a party after non-renewal or termination of the Agreement shall survive such non-renewal or termination regardless of the reason for non-renewal or termination.

17.19. Inconsistencies. If there is inconsistent or contrary language between an attachment attached to this Agreement and any other part of this Agreement, the provisions of the attachment shall prevail with respect to the applicable Products covered by the attachment except to the extent a provision of the Agreement exceeds the minimum requirements of the attachment.

17.20. Cumulative Rights and Remedies. Except as set forth herein, all rights and remedies of a party in this Agreement are cumulative, and in addition to all legal rights and remedies available to the party.

17.21. Counterparts; Electronic Signature. This Agreement may be executed in any number of counterparts, each of which shall be an original, but all of which, together, shall constitute one and the same agreement. The exchange of copies of this Agreement and of signature pages by fax, email or other electronic means shall constitute effective execution and delivery of this Agreement and may be used in lieu of the original Agreement for all purposes.

SIGNATURE PAGE FOLLOWS

SIGNATURE PAGE

IN WITNESS WHEREOF, the undersigned, with the intent to be legally bound, have caused this Agreement to be duly executed and effective as of the Effective Date.

Missouri Care, Incorporated	Print Provider Name: City of Columbia, MO
By: _____ Print Name: _____ Title: _____ Date: _____	By: _____ Print Name: _____ Title: _____ Date: _____
Notice Address for Health Plan: Missouri Care, Incorporated 133 South 11th Street, Suite 200 St. Louis, Missouri 63102 ATTN: Network Management Fax: (314) 444-7575 Email:	Notice Address for Provider: _____ _____ _____ ATTN: _____ Fax: _____ Email: _____

FOR HEALTH PLAN USE ONLY

Effective Date: _____

(Effective Date to be completed by Health Plan following approval of Provider as a Health Plan participating provider, which approval is subject to credentialing. Any attempt by Provider to fill in an effective date shall have no force or effect.)

Initial FEIN for Provider (From W-9):

(Provider may change FEIN upon submission of updated W-9 to Health Plan.)

ATTACHMENT A
MISSOURI HEALTH INSURANCE EXCHANGE
PROGRAM ATTACHMENT

1. Network Participation. Subject to and in accordance with the terms and conditions of the Agreement, including this Attachment, Providers shall provide Covered Services to Members covered by Missouri Health Insurance Exchange Benefit Plans.

2. Compensation for Covered Services provided to Members of Missouri Health Insurance Exchange Benefit Plans is set forth in Attachment B.

3. Additional Definitions. As used in this Attachment and the Agreement:

   a. "**Emergency Medical Condition**" means the sudden and, at the time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity that would lead a prudent layperson, possessing an average knowledge of health and medicine, to believe that immediate medical care is required, which may include, but shall not be limited to: (1) placing the person's health in significant jeopardy; (2) serious impairment to a bodily function; (3) serious dysfunction of any bodily organ or part; (4) inadequately controlled pain; or (5) with respect to a pregnant woman who is having contractions: (a) that there is inadequate time to effect a safe transfer to another hospital before delivery; or (b) that transfer to another hospital may pose a threat to the health or safety of the woman or unborn child. [RSMo 354.400]

   b. "**Emergency Services**" means health care items and services furnished or required to screen and stabilize an Emergency Medical Condition, which may include, but shall not be limited to, health care services that are provided in a licensed hospital's emergency facility by an appropriate provider. [RSMo 354.400]

   c. "**Exchange**" or "**Health Insurance Exchange**" means the Missouri Federally Facilitated Marketplace, established pursuant to section 18031 of the Affordable Care Act.

4. Submission of Federally Facilitated Exchange ("FFE") Data. Provider acknowledges that Health Plan is or may become a party to an agreement with CMS ("CMS Agreement"). In the event that Provider submits or receives FFE data, as defined in the CMS Agreement, Provider, its subcontractors and affiliates are hereby bound by the terms of the CMS Agreement, a copy of which shall be provided to Provider upon request, including Provider's obligation to test software and receive Health Plan's approval of software in the proper format and compatible with the FFE system.

5. Communication with Members. Providers may freely communicate with Members about their treatment and any information that Provider deems appropriate regarding the nature of treatment, risks or alternatives thereto, the availability of other therapy, consultation or test, the decision of Health Plan to authorize or deny services, or the process that Health Plan or any person contracting with Health Plan uses or proposes to use, to authorize or deny health care services or benefits, regardless of benefit coverage limitations. Medical care is the responsibility of the treating health care provider regardless of any coverage determination by Health Plan. [RSMo 354.441]

6. No Interference or Inducement. Nothing in the Agreement or its attachment shall be deemed to (a) require Provider to use a hospitalist (as used in this section, "hospitalist" means a physician who becomes a physician of record at a hospital for a patient of a participating provider and who may return the care of the patient to the participating provider at the end of the hospitalization); or (b) constitute an offer of inducement under the Benefit Plan to Provider to provide less than Medically Necessary services to a Member; or (c) prohibit a Provider from advocating in good faith on behalf of a Member within the utilization review or grievance processes established by Health Plan or a person contracting with Health Plan. [RSMo 354.606.9]

7. Provider Notification. Health Plan shall notify Provider on an ongoing basis of the specific Covered Services covered under a Health Plan Product, including any limitations or conditions on Covered Services, in accordance with the procedures set forth in this Agreement and the Provider Manual. [RSMo 354.606.1]

8. Non-Discrimination of Enrollment Status. Provider shall furnish Covered Services to Members without regard to the Member's enrollment in the Plan as a private purchaser of the Plan or as a participant in a publicly financed program of health care. [RSMo 354.606.14]

9. Hold Harmless. Provider agrees that in no event, including but not limited to nonpayment by Health Plan, insolvency of Health Plan, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Member or any person acting on behalf of the Member, other than Health Plan or an intermediary, for services provided pursuant to this Agreement. This Agreement shall not prohibit Provider from collecting coinsurance, deductibles or co-payments, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to Members. This Agreement shall not prohibit Provider, except for a health care professional who is employed full time on the staff of a health carrier and has agreed to provide service exclusively to that health carrier's enrollees and no others, and a Member from agreeing to continue services solely at the expense of the Member, as long as Provider has clearly informed the Member that Health Plan may not cover or continue to cover a specific service or services. Except as provided herein, this Agreement does not prohibit Provider from pursuing any available legal remedy; including, but not limited to, collecting from any insurance carrier providing coverage to a covered person. This section shall: (1) survive the expiration or termination of the Agreement, regardless of the reason for termination, including the insolvency of Health Plan; and (2) supersede any oral or written contrary agreement between Provider and a Member or the representative of a Member if the contrary agreement is inconsistent with this section or any other section of the Agreement. [RSMo 354.606; RSMo 354.612.2; 20 CSR 400-7.080]

10. Continuation of Services. In the case of Health Plan's insolvency or other cessation of operations, Health Plan shall continue to cover services to Members for the period for which a premium has been paid to Health Plan on behalf of the Member or until the Member's discharge from an inpatient facility, whichever time is greater. [RSMo 354.606] This section shall: (1) survive the expiration or termination of the Agreement, regardless of the reason for termination, including the insolvency of Health Plan; and (2) supersede any oral or written contrary agreement between Provider and a Member or the representative of a Member if the contrary agreement is inconsistent with this section or any other section of the Agreement. [RSMo 354.606]

11. Access to Health Records. Provider shall make health records available (a) to appropriate Governmental Authorities involved in (i) assessing the quality of care, but shall not disclose individual identities, or (ii) investigating the grievances or complaints of Members, and (b) to comply with the applicable Laws related to the confidentiality of medical or health records. [RSMo 354.606.12]

12. Provider to Furnish Records. Health Plan shall monitor, on an ongoing basis, the ability, clinical capacity, and legal authority of Provider to furnish all Covered Services to Members. This section shall not be construed to require Provider to submit copies of Provider's income tax returns to Health Plan. Health Plan may require Provider to obtain audited financial statements if Provider receives ten percent or more of the total medical expenditures made by Health Plan. [RSMo 354.603.1(3)]

13. Member Access to Entire Network. Notwithstanding legitimate and medically based referral patterns, neither party shall act in a manner that unreasonably restricts a Member's access to Health Plan's entire provider network, unless Health Plan has a written agreement with the Member to a reduced network, and has requested an exception for a reduced network pursuant to 20 CSR 400-7.095 and RSMo 354.603.

14. Assignment or Delegation. The rights and responsibilities of Provider under this Agreement shall not be assigned or delegated by Provider without the prior written consent of Health Plan. [RSMo 354.606.13]

15. Administrative Policies. Provider's responsibilities with respect to Health Plan's applicable administrative policies and programs, including payment terms, utilization review, quality assessment and improvement programs, credentialing, grievance procedures, data reporting requirements, confidentiality requirements and any applicable federal or state programs, are set forth in the Provider Manual. [RSMo 354.606.8]

16. Member Cost Sharing. Provider's obligations, if any, to collect applicable coinsurance, co-payments or deductibles from Members pursuant to the Member's evidence of coverage, or Provider's obligations, if any, to notify Members of their personal financial obligations for non-Covered Services are set forth in the Provider Manual. [RSMo 354.606.15]

17. Member Eligibility. Health Plan's mechanism by which Provider may determine in a timely manner whether a Member is covered by Health Plan is set forth in the Provider Manual. [RSMo 354.606.17]

18. Non-renewal. Either party may exercise a right of non-renewal at the expiration of the contract term or upon 60 days' written notice to the other party and such non-renewal shall be deemed a termination under the termination provisions of the Agreement; provided, however, that any non-renewal shall not constitute a termination for purposes of RSMo 354.609.

19. Either party may terminate this Agreement, in whole or with respect to any particular Program, Benefit Plan or Provider, at any time for any reason or no reason upon at least 60 days' written notice to the other party. Such notice shall include an explanation of why the contract is being terminated. [RSMo 354.609.1] In the event that Health Plan terminates the Agreement without cause, Provider shall be afforded an opportunity for review or a hearing pursuant to RSMo 354.609.2, unless the termination involves imminent harm to patients, a determination of fraud, or a final disciplinary action by a state licensing board or other governmental agency.

20. Good Faith Acts. Health Plan shall not terminate the Agreement solely or in part because Provider, in good faith: (1) advocates on behalf of a Member; (2) files a complaint against Health Plan; (3) appeals a decision of Health Plan; (4) provides information or files a report with the Missouri Department of Insurance, financial institutions and professional registration; or (5) requests a hearing or review pursuant to the Agreement or RSMo 354.609.

21. Upon non-renewal or termination of this Agreement, Health Plan will communicate such non-renewal or termination to Members in accordance with RSMo 354.609, irrespective of whether the termination was for or without cause. [RSMo 354.609.1]

22. List of Members. Within 15 business days of the date that Provider either gives or receives notice of termination for any reason, Provider shall supply Health Plan with a list of those patients of Providers that are Members of Health Plan. [RSMo 345.609(1)]

23. Continuation of Care. In the event this Agreement is terminated or non-renewed for any reason other than for reasons requiring immediate termination by the Health Plan, Health Plan shall allow affected Members continued access to Provider for a period of up to 90 days where the continuation of care is Medically Necessary and in accordance with the dictates of medical prudence, including circumstances such as disability, pregnancy, or life-threatening illness. Under such circumstances, Member shall not be liable to Provider for any amounts owed for medical care other than deductibles or co-payment amounts specified in the certificate of coverage or other contract between the Member and Health Plan. In the event the Agreement is terminated and Provider is authorized to continue treating a Member pursuant to this section, Health Plan is obligated to pay Provider at the previously contracted rate for services provided to the Member. [RSMo 354.612].

24. Section 17.2 Independent Contractors will survive the termination of the Agreement regardless of the

cause of the termination and its terms are applicable to, and binding upon, all individuals with whom Provider may subcontract to provide services to Health Plan's Members. [20 CSR 400-7.080]

25. Adequate Time to Review. Provider acknowledges that Provider has either had an opportunity to review this Agreement for 30 days prior to execution, or hereby waives such 30 day review period. [RSMo 354.609.6]

26. Prompt Payment. Health Plan shall pay or deny a Clean Claim within 30 days of its receipt of an electronically filed Clean Claim. The date of receipt of a Clean Claim shall be the date Health Plan receives the Clean Claim electronically. [RSMo 376.383; RSMo 376.384] The date of payment shall be the date of the Electronic Funds Transfer or Electronic Remittance Advice or other form of payment.

27. Assignment of Benefits. Benefits payable under this Agreement shall be paid, with or without an assignment of benefits from the Member, to public hospitals and clinics for health care services and supplies provided to the Member if a Clean Claim is submitted by the public hospital or clinic as specified in section RSMo 376.778.2 and if benefits have not been paid to the Member prior to receipt of the Claim by Health Plan. Payment of benefits to the public hospital or clinic by Health Plan shall discharge Health Plan from all liability to the Member to the extent of benefits paid. Under no circumstances, however, shall payment of duplicate benefits to both the Member and the public hospital or clinic for the same services or supplies be required. [20 CSR 100-1.300]

28. No Risk Sharing Arrangement. This Agreement shall not be construed as creating a risk sharing agreement between Health Plan and Provider. In the event that the parties amend this Agreement to create a risk sharing arrangement, Health Plan shall file such arrangement with the Missouri Director of Insurance pursuant to RSMo 354.624.1.

ATTACHMENT B
HEALTH INSURANCE EXCHANGE
FEE FOR SERVICE COMPENSATION
PHYSICIAN / PROFESSIONAL

1. The compensation rates set forth in this Attachment apply to Benefit Plans offered through the Health Insurance Exchanges in the Individual Market as set forth in the applicable Program Attachment. Compensation shall be subject to and in accordance with the terms and conditions of the Agreement, including this Attachment and its appendices.

2. Compensation. Fee for service compensation for Covered Services provided to Members shall be the lesser of the Provider's billed charges, or the following, less Member Cost Sharing:

   100 percent of the applicable CMS Medicare fee schedule for the applicable locality published on the CMS website on the date the Covered Services are rendered, subject to the adjustments in this Attachment.

   In the event that CMS does not publish a reimbursement rate for a Covered Service, Health Plan will compensate Provider by using Health Plan's Health Insurance Exchange fee schedule. Health Plan's Health Insurance Exchange fee schedule includes the applicable CMS monetary conversion factor, applies a proprietary resource-based relative value scale ("RBRVS") obtained from industry standard sources, is adjusted for CMS's geographic practice cost indexes, and is limited to Outpatient Perspective Payment System (OPPS) capped amounts where applicable.

3. Health Plan's Health Insurance Exchange fee schedule is available on Health Plan's provider website.

4. Compensation is based on the nature of the service provided and the credentials of the rendering provider (e.g. - primary care or specialty care, ARNP, LCSW, etc.), rather than the designation of the practitioner as a Primary Care Physician or Specialist.

5. With regard to the Medicare fee schedule, Health Plan implements and prospectively applies CMS's changes to its Medicare fee schedules as of the later of (i) the effective date of the change, or (ii) 45 days from the date CMS publishes the change on its website. Health Plan will not retrospectively apply rate changes to claims that have already been paid.

6. Compensation is subject to the following adjustments:

   a. Payment of compensation is subject to coordination of benefits and subrogation activities and adjustments. Provider shall bill primary insurers for services Provider provides to a Member before it submits claims for the same services to Health Plan. If Health Plan is not the primary payor for Covered Services provided to a Member, then Health Plan's responsibility for such services shall not exceed the compensation in this Agreement less amounts payable by the primary payor or payors, and Member Cost Sharing.

   b. Health Plan uses claims editing software programs to assist it in determining proper coding for provider claim reimbursement. Such software programs use industry standard coding criteria and incorporate guidelines established by coding authorities, such as CMS, State Medicaid agencies, the National Correct Coding Initiative, the National Hospital Fee Schedule Database, the National Physician Fee Schedule Database, the AMA and Specialty Society correct coding guidelines, and applicable State specific regulations (collectively, "Coding Authorities"). These software programs may result in claim edits for specific procedure codes or combinations.

   c. With regard to the CMS Medicare fee schedule, Health Plan automatically updates code numbers or deletes retired codes, as the codes are revised or implemented by Coding Authorities, without notice to Provider or amendment of this Agreement. Where applicable, such as for value added benefits covered by a Benefit Plan, Health Plan may, in its sole discretion, determine rates for

items and services that are Covered Services but not included in the applicable CMS Medicare fee schedule published on CMS's website.

d. If Provider provides professional services that are Covered Services to a Member in a facility that has Hospital-Based Status (as defined in 42 CFR 413.65), Health Plan shall only pay professional fees for such Covered Services, and shall not pay facility charges. Provider agrees not to bill Members for facility charges or to include such charges in the calculation of Member Cost Sharing.

7. Health Plan will implement and prospectively apply changes to Health Plan's rate schedules upon 30 days' notice to Provider, or such other time required under State Laws. Health Plan will not retrospectively apply changes to Health Plan's rate schedule to any claims that have already been paid.

Fee Appendix 1
Missouri Health Insurance Exchange

1. Health Plan shall compensate Provider for the CPT Codes listed below at the rates set forth below.

Table 1: Missouri Health Insurance Exchange		
Description of Item or Service	**CPT Codes**	**Percentage of Medicare Fee Schedule**
All services not listed below		100
Evaluation and Management	99201-99215	105
Preventive Medicine	99381-99429	105
Radiology	70000-79999	70
Laboratory; except listed below	80000-89999	70
Venipuncture	36415	100
Urinalysis dipstick w/ microscopy	81000	100
Urinalysis dipstick w/out microscopy	81002	100
Urinalysis non-automated w/out microscopy	81003	100
Urine pregnancy test	81025	100
Urine, micro-albumin, semi-quantitative	82044	100
Blood glucose testing (finger stick)	82962	100
Lead screening	83655	100
CBC automated and automated WBC count	85025	100
CBC, automated	85027	100
Prothrombin time	85610	100
Tuberculosis skin test	86580	100
Rapid HIV	86703	100
Wet mount for infectious agents	87210	100
Influenza test	87804	100
Streptococcus, Group A	87880	100
Speech Therapy	92507-92508	70
Physical Therapy	97001-97755	70
Occupational Therapy	97003-97004	70
DME, Prosthetics; Supplies	E0100-E9999; L0000-L9999; A4000-A8999	70

Source: Health

Agenda Item No:

To: City Council

From: City Manager and Staff

Council Meeting Date: Apr 7, 2014

Re: Missouri Care Incorporated (a WellCare Company) Health Plan Participating Provider Agreement

EXECUTIVE SUMMARY:

A resolution authorizing the City Manager to sign the Participating Provider Agreement between the City of Columbia and Missouri Care Incorporated (a WellCare Company) Health Plan. The effective date for this agreement is based on agency signature and will continue unless terminated in writing by either party.

DISCUSSION:

This agreement allows the Department of Public Health and Human Services to obtain reimbursement for approved clinical services provided for WellCare participants. This will also allow clients with Missouri Care to obtain services whether covered by Missouri Care Medicaid or through the commercial insurance offered by the same company. Reimbursement rates are based on percentage of Medicare fees as shown on Fee Appendix 1.

FISCAL IMPACT:

This is a new agreement. Revenues will be dependent on the number of WellCare participants who seek services from Public Health and Human Services. No appropriation is necessary.

VISION IMPACT:
http://www.gocolumbiamo.com/Council/Meetings/visionimpact.php

11.3 Goal: Columbia will be a healthy community. All residents will have timely access to appropriate health care. Effective prevention initiatives will contribute to a healthy community.

SUGGESTED COUNCIL ACTIONS:

Should the Council agree with the staff recommendation, an affirmative vote is in order.

FISCAL and VISION NOTES:					
City Fiscal Impact Enter all that apply		**Program Impact**		**Mandates**	
City's current net FY cost	$0.00	New Program/ Agency?	No	Federal or State mandated?	No
Amount of funds already appropriated	$0.00	Duplicates/Epands an existing program?	No	**Vision Implementation impact**	
Amount of budget amendment needed	$0.00	Fiscal Impact on any local political subdivision?	No	Enter all that apply: Refer to Web site	
Estimated 2 year net costs:		**Resources Required**		Vision Impact?	Yes
One Time	$0.00	Requires add'l FTE Personnel?	No	Primary Vision, Strategy and/or Goal Item #	11.3
Operating/ Ongoing	$0.00	Requires add'l facilities?	No	Secondary Vision, Strategy and/or Goal Item #	
		Requires add'l capital equipment?	No	Fiscal year implementation Task #	