COCHISE COUNTY GRANT APPROVAL FORM

Form Initiator: JENNIFER STEIGER

Date Prepared: Oct 17, 2014

Point of Contact: JENNIFER STEIGER

Phone Number: 520-432-9402

Department: Health

PRIMARY GRANT

Primary Grantor: BRIDGEWAY HEALTH SOLUTIONS

CFDA: www.CFDA.gov

Grant Title: ANCILLARY SERVICES PROVIDER AGREEMENT

Grant Term From: Oct 28, 2014 To: Oct 27, 2017

Total Award Amount: 0

New Grant: ☐ Yes ☒ No

Grant No.: N/A

Amendment No.:

Funding No.: 100-5000-5200 If new, Finance will assign a funding number.

Strategic Plan: Health & Wellbeing

District: CW

Mandated by Law? ☐ Yes ☒ No

Number of Positions Funded: 0

Asset(s) Acquired:

Briefly describe the purpose of the grant.

The specific intent of this agreement is so that CHSS can administer influenza vaccinations to the ALTCS clients and bill Bridgeway and/or the clients' primary insurance for these services. This agreement will generate revenue, or cover CHSS costs.

If this is a mandated service, cite the source. If not mandated, cite indications of local customer support for this service.

NOT MANDATED

PRIMARY FUNDING SOURCE:

Funding Year:	2014-2015	Federal Funds 332.100	
		State Funds 336.100	
		County Funds 391.000	
		Other Funds:	
		Total Funds:	
Funding Year:		Federal Funds 332.100	
		State Funds 336.100	
		County Funds 391.000	
		Other Funds:	
		Total Funds:	
Funding Year:		Federal Funds 332.100	
		State Funds 336.100	
		County Funds 391.000	
		Total Revenue:	

Has this amount been budgeted? ☒ Yes ☐ No

Method of collecting funds: ☐ Lump Sum ☐ Quarterly ☐ Draw ☐ Reimbursement

Is revertment of unexpended funds required at the end of grant period? ☐ Yes ☐ No

(a) Total A-87 Cost Allocation: 0 (b) Amount of overhead allowed by grant: 0

County Subsidy (a) - (b): 0

Does Grantor accept indirect costs as an allowable expenditure? ☐ Yes ☒ No

If yes, dollar amount or percentage allowed:

Second Grantor:

Grant Term From: To:

Secondary Award Amount:

Grant No.:

Amendment No.:

Funding Year:

Federal Funds 332.100

State Funds 336.100

County Funds 391.000

Other Funds:

Funding Year:

Federal Funds 332.100

State Funds 336.100

County Funds 391.000

Other Funds:

Total Revenue:

Has this amount been budgeted? ☐ Yes ☐ No

Method of collecting funds: ☐ Lump Sum ☐ Quarterly ☐ Draw ☐ Reimbursement

Is revertment of unexpended funds required at the end of grant period? ☐ Yes ☐ No

(a) Total A-87 Cost Allocation: (b) Amount of overhead allowed by grant:

County Subsidy (a) - (b):

Does Grantor accept indirect costs as an allowable expenditure? ☐ Yes ☐ No

If yes, dollar amount or percentage allowed:

Is County match required? ☐ Yes ☐ No

County Match Source:

County match dollar amount or percentage:

Signature: J. STEIGER

Board Approval: Date

Print Form

Submit by Email to Finance Please e-mail completed form to Finance ldevore@cochise.az.gov.

NOTE: Once approved by the Board of Supervisors, the department is responsible for sending a copy of the fully executed grant document to the Finance Department

Executive Summary Form

Agenda Number: HLT Provider Services Agreement

Recommendation:

Approve **Ancillary Services Provider Agreement** between Bridgeway Health Solutions and the Cochise Health and Social Services (CHSS) Department for the period of 10/28/14 for three years. The Agreement will automatically renew for terms of one (1) year each.

Background (Brief):

This is agreement will allow CHSS staff to provide services for Bridgeway members. The specific intent of this agreement is so that CHSS can administer influenza vaccinations to the ALTCS clients and bill Bridgeway and/or the clients' primary insurance for these services.

Fiscal Impact & Funding Sources:

This agreement will generate revenue, or at least cover costs, for administration of these vaccines. Bridgeway and/or the clients' primary insurance will pay CHSS for these services at the then current Medicare or AHCCCS fee schedule. This agreement can be expanded to cover other direct services CHSS provides to Bridgeway members in the future with the same reimbursement methodology. cost reimbursement program through the Arizona Department of Health Services in the amount of $331,050. The ADHS allowable indirect rate for this program is 15% versus the county A-87 rate of 46.98%. The result in a net County subsidy of $81,842:

Personnel / EREs:	No Additional
A-87 OH Rate @ 46.98%:	No Additional
Authorized OH @ 15%:	No Additional
Net County Subsidy:	**$ 0**

Next Steps/Action Items/Follow-up: Your approvals are respectfully requested.

Impact of Not Approving:
Not approving this amendment would result in CHSS staff not being able to provide and bill for direct services to Bridgeway clients and a loss of this revenue stream.

ANCILLARY SERVICES PROVIDER AGREEMENT

THIS ANCILLARY SERVICES PROVIDER AGREEMENT ("Agreement") is made and entered into as of _____ ("Effective Date"), by and between Cochise County Health Department ("Provider") and Bridgeway Health Solutions, L.L.C. ("MCO").

WHEREAS, Provider is a provider of Clinic services duly licensed and operating in accordance with all applicable State and federal laws and regulations; and

WHEREAS, MCO is a duly licensed managed care organization authorized to arrange for the provision of Covered Services to Covered Persons (as hereinafter defined); and

WHEREAS, MCO wishes to contract with Provider to provide certain Covered Services to Covered Persons; and

WHEREAS, Provider desires to provide the Covered Services specified in this Agreement to Covered Persons for the consideration, and under the terms and conditions, set forth in this Agreement; and

NOW, THEREFORE, in consideration of the premises and mutual promises herein stated, the parties hereby agree as follows:

ARTICLE I
DEFINITIONS

As used in this Agreement and each of its Attachments, each of the following terms (and the plural thereof, when appropriate) shall have the meaning set forth herein.

1.1. ***Affiliate(s)*** means a person or entity controlling, controlled by, or under common control with MCO.

1.2. ***Attachment(s)*** means the attachments to this Agreement, including addenda and exhibits, all of which are hereby incorporated herein by reference.

1.3. ***Clean Claim*** has, as to each particular product, the meaning set forth in the Attachment pertaining to each such product. If there is no definition for a particular product, "Clean Claim" shall have the meaning set forth in the Provider Manual.

1.4. ***Covered Person*** means a person eligible for and enrolled in MCO or an Affiliate to receive Covered Services.

1.5. ***Covered Services*** means those Medically Necessary health care services covered under the terms of the applicable Payor Contract and rendered in accordance with the Provider Manual.

1.6. ***Emergency or Emergency Care*** has, as to each particular product, the meaning set forth in the Attachment pertaining to each such product. If there is no definition for a particular product, Emergency Care shall mean inpatient and outpatient Covered Services furnished by a qualified provider that are needed to evaluate or stabilize an Emergency Medical Condition.

1.7. ***Emergency Medical Condition*** means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) 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 the following: (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; or (iii) serious dysfunction of any bodily organ or part.

1.8. ***Medical Director*** means a duly licensed physician or his/her physician designee designated by MCO to monitor and evaluate the appropriate utilization of Covered Services by Covered Persons.

1.9. ***Medically Necessary*** means, unless otherwise defined in the applicable Attachment, any health care services determined by MCO's Medical Director or Medical Director's designee to be required to preserve and maintain a Covered Person's health, provided in the most appropriate setting and in a manner consistent with the most appropriate type, level, and length of service, which can be effectively and safely provided to the Covered Person, as determined by acceptable standards of medical practice and not solely for the convenience of the Covered Person, Covered Person's physician, Provider or other health care provider.

1.10. ***Participating Health Care Provider*** means any physician, hospital, ancillary, or other health care provider that has contracted directly or indirectly with MCO to provide Covered Services to Covered Persons and is credentialed in accordance with the MCO's credentialing criteria.

1.11. ***Payor*** means MCO or another entity that is responsible for funding Covered Services to Covered Persons.

1.12. ***Payor Contract*** means MCO's contract with any Payor that governs provision of Covered Services to Covered Persons. Where MCO is the Payor, "Payor Contract" means MCO's contract with the State or federal agency or other entity that has contracted with MCO to arrange for the provision of Covered Services to eligible individuals of such agency or other entity.

1.13. ***Provider Manual*** means the MCO manual of policies, procedures, and requirements to be followed by Participating Health Care Providers. The Provider Manual includes, but is not limited to, utilization management, quality management, grievances and appeals, and Payor-specific program requirements, and may be changed from time to time by MCO.

1.14. ***State*** is defined as the state set forth in the Attachment(s) attached hereto.

ARTICLE II
MCO'S OBLIGATIONS

2.1. Administration. MCO shall be responsible for the administrative activities necessary or required for the commercially reasonable operation of a managed care organization. Such activities shall include, but are not limited to, quality improvement, utilization management, grievances and appeals, claims processing, and maintenance of provider directory and records.

2.2. Provider Manual. MCO shall make the Provider Manual available to Provider via MCO's website and upon Provider's request. MCO shall post changes to the Provider Manual on MCO's website or provide Provider with prior written notice of material changes to the Provider Manual.

2.3. Identification Cards. MCO or Payor shall issue to Covered Persons an identification card that shall bear the name of the Covered Person, and a unique identification number.

2.4. Benefits and Eligibility Verification. MCO or Payor, as determined by the Payor Contract, shall be responsible for all eligibility and benefit determinations regarding Covered Services and all communications to Covered Persons regarding final benefit determinations, eligibility, bills, and other matters relating to their status as Covered Persons.

2.5. MCO's Medical Director. MCO shall provide a Medical Director to be responsible for the professional and administrative medical affairs of MCO.

ARTICLE III
PROVIDER'S OBLIGATIONS

3.1. Covered Services. Provider shall provide to Covered Persons those Covered Services described in the applicable Attachment(s) in accordance with the Provider Manual and according to the generally accepted standards of medical practice in the Provider's community, the scope of Provider's license, and the terms and conditions of this Agreement. Provider shall make necessary and appropriate arrangements to assure the availability of Covered Services to Covered Persons during business hours consistent with like providers and in accordance with applicable State and federal law and the Payor Contract.

3.2. Compliance with MCO Policies and Procedures. Provider warrants that Provider and all persons providing services hereunder on Provider's behalf ("Provider Personnel"), shall at all times cooperate and comply with the policies and procedures of MCO, including, but not limited to, the following:

A. MCO's credentialing criteria;

B. MCO's Provider Manual;

C. MCO's medical management program including quality improvement, utilization management, disease management, and case management;

D. MCO's grievance and appeal procedures; and

E. MCO's coordination of benefits and third party liability policies.

3.3. Determination of Covered Person Eligibility. Provider shall verify, in accordance with the Provider Manual, whether an individual seeking Covered Services is a Covered Person. If MCO determines that such individual was not eligible for Covered Services at the time the services were rendered, such services shall not be eligible for payment under this Agreement, and Provider may bill the individual or other responsible entity for such services.

3.4. Emergency Care. Provider shall provide Emergency Care in accordance with applicable federal and State laws and the Payor Contract. Provider shall notify MCO within twenty-four (24) hours or by the next business day of rendering or learning of the rendering of Emergency Care to a Covered Person.

3.5. Acceptance of New Patients. To the extent that Provider is accepting new patients, Provider must also accept new patients who are Covered Persons of MCO. Provider shall provide MCO forty-five (45) days written notice prior to Provider's decision to no longer accept Covered Persons of MCO or any other Payor. In no event shall any established patient of Provider who becomes a Covered Person be considered a new patient.

3.6. Referrals: Reporting to Primary Care Physician. Provider shall provide Covered Services to Covered Persons upon referral from a MCO primary care physician ("PCP") or MCO, and shall arrange for any appropriate referrals and/or admissions of Covered Persons, in accordance with the requirements of the Provider Manual. Provider shall, within a reasonable time following consultation with, or testing of, a Covered Person (not to exceed one (1) week), make a complete written report to the Covered Person's PCP, provided that, with respect to findings which may indicate a need for immediate or urgent follow-up treatment or testing or which may indicate a need for further or follow-up care outside the scope of the referral authorization or outside the scope of Provider's area of expertise, the Provider shall provide an immediate oral report to the Covered Person's PCP, not to exceed twenty-four (24) hours from the time of Provider's consultation or Provider's receipt of the report of the testing, as applicable.

3.7. Preferred Drug List/Drug Formulary. If applicable to the Covered Person's coverage, Provider shall abide by MCO's formulary or preferred drug list when prescribing medications for Covered Persons.

3.8. Treatment Decisions. MCO shall not be liable for, nor will it exercise control over, the manner or method by which Provider provides or arranges for Covered Services. Provider understands that MCO's determinations, if any, to deny payments for services which MCO does not deem to constitute Covered Services or which were not provided in accordance with the requirements of this Agreement, the Attachments or the Provider Manual, are administrative decisions only. Such a denial does not absolve Provider of Provider's responsibility to exercise independent judgment in Covered Person treatment decisions. Nothing in this Agreement is intended to interfere with Provider's provider-patient relationship with Covered Person(s).

3.9. Facilities. Provider agrees that the facilities at which Covered Services are provided hereunder shall be maintained in accordance with all applicable federal and State laws.

3.10. Covered Person Communication. Provider shall obtain Payor and MCO's approval for Covered Person communication as required by the Payor Contract and applicable State and federal law. Nothing in this Agreement shall be construed as limiting Provider's ability to communicate with Covered Persons with regard to quality of health care or medical treatment decisions or alternatives regardless of Covered Service limitations under the Payor Contract.

3.11. Cooperation with MCO Carve-Out Vendors. Provider acknowledges that MCO may, during the term of this Agreement, carve-out certain Covered Services from its general provider contracts, including this Agreement, as MCO deems necessary to promote the quality and cost-effectiveness of services provided to Covered Persons. Provider shall cooperate with any and all third party vendors that have contracted with MCO or an Affiliate of MCO to provide services to Covered Persons.

3.12. Disparagement Prohibition. Provider agrees not to disparage MCO in any manner during the term of this Agreement or in connection with any expiration, termination or non-renewal of this Agreement. Provider shall not interfere with MCO's contractual relationships including, but not limited to, those with other Participating Health Care Providers. Nothing in this provision, however, shall be construed as limiting Provider's ability to inform patients that this Agreement has been terminated or otherwise expired or to promote Provider to the general public or to post information regarding other health plans consistent with Provider's usual procedures, provided that no such promotion or advertisement is directed at any specific Covered Person or group of Covered Persons.

3.13. Nondiscrimination. Provider will provide services to Covered Persons without discrimination on account of race, sex, sexual orientation, age, color, religion, national origin, place of residence, health status, type of Payor, source of payment, physical or mental disability or veteran status, and will ensure that its facilities are accessible as required by Title III of the Americans With Disabilities Act of 1991 ("ADA"). Provider recognizes that as a governmental contractor, MCO is subject to various federal laws, executive orders and regulations regarding equal opportunity and affirmative action, which also may be applicable to subcontractors.

3.14. Written Notice. Provider shall give written notice to MCO of: (i) any situation which develops regarding Provider, when notice of that situation has been given to the State agency that licenses Provider, or any other licensing agency or board, or any situation involving an investigation or complaint filed by the State agency that licenses Provider, or any other licensing agency or board, regarding a complaint against Provider's license; (ii) when a change in Provider's license to practice medicine is affected or any form of reportable discipline is taken against such license; (iii) suspension or exclusion under a federal health care program, including, but not limited to, Medicaid; (iv) any government agency request for access to records; or (v) any lawsuit or claim filed or asserted against Provider alleging professional malpractice, regardless of whether the lawsuit or claim involves a Covered Person. In any such instance described above, Provider must notify MCO in writing within ten (10) days from the date Provider first receives notice, whether written or oral, with the exception of those lawsuits or claims which do not involve a Covered Person, with respect to which Provider has thirty (30) days to notify MCO.

3.15. Use of Name. Provider agrees that MCO may use Provider's name, address, phone number, type of practice, and an indication of Provider's willingness to accept additional Covered Persons in MCO's roster of Participating Health Care Providers and marketing materials.

ARTICLE IV
COMPLIANCE WITH LAW

4.1. Compliance with Law and Payor Contracts. Provider and MCO agree that each party shall carry out its obligations in accordance with terms of the Payor Contract and applicable federal and State laws and regulations, including, but not limited to, the requirements of the Stark law (42 U.S.C. § 1395nn) and applicable federal and State self-referral and fraud and abuse statutes and regulations. If, due to Provider's noncompliance with law, the Payor Contract or this Agreement, sanctions or penalties are imposed on MCO, MCO may, in its sole discretion, offset sanction or penalty amounts against any amounts due Provider from MCO or require Provider to reimburse MCO for the amount of any such sanction or penalty.

4.2. HIPAA Compliance. Provider and MCO shall abide by the administrative simplification provisions of the Health Insurance Portability and Accountability Act ("HIPAA"), its implementing regulations [45 C.F.R. parts 160 and 164] and all other federal and State laws regarding confidentiality and disclosure of medical records and other health and Covered Person information, including safeguarding the privacy and confidentiality of any protected health information ("PHI") that identifies a particular Covered Person. Provider shall assure its own compliance and that of its business associates with HIPAA.

ARTICLE V
CLAIMS SUBMISSION, PROCESSING, AND COMPENSATION

5.1. Claims or Encounter Submission. Provider shall submit to Payor claims or encounters for Covered Services in accordance with the Provider Manual. Payor reserves the right to

deny payment to Provider if Provider fails to submit in accordance with the Provider Manual. If applicable based on Provider's compensation arrangement, Provider shall submit encounter data to Payor in a timely fashion, which shall contain such statistical and descriptive medical and patient data and identifying information as specified in the Provider Manual.

5.2. Compensation. Payor shall pay Clean Claims from Provider for Covered Services provided to Covered Persons in accordance with the applicable exhibit less any applicable copayments, cost-sharing or other amounts that are the Covered Person's financial responsibility.

5.3. Financial Incentives. Nothing in this Agreement shall, or shall be construed to, create any financial incentive for Provider to withhold Medically Necessary services.

5.4. Covered Person Hold Harmless. Provider agrees that in no event including, but not limited to, non-payment by MCO, MCO insolvency, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Covered Person for Covered Services provided pursuant to this Agreement. This provision shall not prohibit collection of any applicable copayments or other amounts that are the Covered Person's financial responsibility. This provision shall survive termination or expiration of this Agreement for any reason, shall be construed for the benefit of Covered Persons, and supersedes any oral or written agreement entered into between the Provider and a Covered Person.

5.5. Recoupment Rights. Payor shall have the right to immediately recoup any and all amounts owed by Provider to Payor or any Affiliate against amounts owed by Payor or Affiliate to Provider. Provider agrees that all recoupment and any offset rights under this Agreement shall constitute rights of recoupment authorized under State or federal law and that such rights shall not be subject to any requirement of prior or other approval from any court or other government authority that may now have or hereafter have jurisdiction over Provider.

ARTICLE VI
RECORDS/INSPECTIONS

6.1. Medical Records/Advance Directives. Provider shall maintain a complete and accurate permanent medical record for each Covered Person to whom Provider renders services under this Agreement and shall include in that record all reports from Participating Health Care Providers and all documentation required by applicable law, regulations, professional standards and the Provider Manual. Provider shall document in the Covered Person's medical record whether the Covered Person has executed an advance directive and agrees to comply with all federal and State laws regarding advance directives. Medical records of Covered Persons shall be treated as confidential so as to comply with all federal and State laws and regulations regarding the confidentiality of the patient records.

6.2. Records. Provider shall maintain records related to services provided to Covered Persons and provide such medical, financial and administrative information to MCO and State and federal government agencies as may be necessary for compliance by MCO with State and federal law and accreditation standards, as well as for the administration of this Agreement. MCO shall have access at reasonable times to books, records, and papers of the Provider relating to the health care services provided to Covered Persons for Covered Services.

6.3. Consent to Release Medical Records. Provider shall obtain Covered Person authorizations relative to the release of medical information required by applicable law to provide MCO or other authorized parties with access to Covered Persons' records.

6.4. Access. In accordance with applicable law, Provider shall provide access to Provider's records to the following, including any designee or duly authorized agent:

A. Payors, during regular business hours and upon prior notice;

B. government agencies, to the extent such access is necessary to comply with regulatory requirements that apply to MCO or Payors; and

C. accreditation agencies.

Provider shall provide copies of records at no expense.

6.5. Record Transfer. Subject to applicable law and Payor Contract requirements, Provider shall cooperate in the timely transfer of Covered Persons' medical records to any other health care provider at no charge and when required.

6.6. On-Site Inspections. Provider agrees that medical office space or its facilities, as applicable, shall be maintained in accordance with applicable federal and State regulatory requirements. Provider shall cooperate in on-site inspections of medical office space by MCO, authorized government officials, and accreditation bodies. Provider shall compile any and all information in a timely manner required to evidence Provider's compliance with this Agreement, as requested by such agency(ies), or as otherwise necessary for the expeditious completion of such on-site inspection.

ARTICLE VII
INSURANCE

7.1. Provider Insurance. During the term of this Agreement, Provider shall maintain policies of general and professional liability insurance and other insurance that are necessary to insure Provider, and any other person providing services hereunder on Provider's behalf, against any claim(s) of personal injuries or death alleged or caused by Provider's performance under this Agreement. Such insurance shall include, but not be limited to, tail or prior acts coverage necessary to avoid any gap in coverage. Insurance shall be through a licensed carrier, and in a minimum amount of one million dollars ($1,000,000)

per occurrence, and have an annual aggregate of no less than three million dollars ($3,000,000) unless a lesser amount is accepted by MCO or where State law mandates otherwise. Provider will provide MCO with at least fifteen (15) days notice of such cancellation, non-renewal, lapse, or adverse material modification of coverage. Upon MCO's request, Provider will furnish MCO with evidence of such insurance.

7.2. Other Insurance. All parties to this Agreement shall maintain in full force and effect appropriate workers' compensation protection and unemployment insurance as required by law.

ARTICLE VIII
INDEMNIFICATION

8.1. MCO Indemnification. Provider agrees to indemnify and hold harmless (and at MCO's request defend) MCO, its Affiliates, officers, employees and agents from and against any and all claims, loss, damages, liability, costs, expenses (including reasonable attorney's fees), judgments, or obligations arising from or in connection with third party claims alleging any negligence or otherwise wrongful act or omissions of Provider, its agents or employees in the performance of Provider's obligations under this Agreement.

8.2. Provider Indemnification. MCO agrees to indemnify and hold harmless (and at Provider's request defend) Provider, its officers, employees and agents from and against any and all claims, loss, damages, liability, costs, expenses (including reasonable attorney's fees), judgments, or obligations arising from or in connection with third party claims alleging any negligence or otherwise wrongful act or omission of MCO, its agents or employees in the performance of MCO's obligations under this Agreement.

ARTICLE IX
DISPUTE RESOLUTION

9.1. Informal Dispute Resolution. Any disputes between the parties arising with respect to the performance or interpretation of this Agreement ("Dispute") shall first be resolved by exhausting the processes available in the Provider Manual, then through good faith negotiations between designated representatives of the parties that have authority to settle the Dispute. If the matter has not been resolved within sixty (60) days of the request for negotiation, either party may initiate arbitration in accordance with the Arbitration section of this Agreement by providing written notice to the other party.

9.2. Arbitration. If a Dispute is not resolved in accordance with the Informal Dispute Resolution section of this Agreement, either party wishing to pursue the Dispute shall submit it to binding arbitration conducted in accordance with the Commercial Arbitration Rules of the American Arbitration Association ("AAA"). In no event may any arbitration be initiated more than one (1) year following the end of the sixty (60) day negotiation period of the Informal Dispute Resolution section of this Agreement. Arbitration proceedings shall be conducted at a mutually agreed upon location within the State. The arbitrators shall have no right to award any punitive or exemplary damages or to vary or

ignore the terms of this Agreement and shall be bound by controlling law. Each party shall bear its own costs related to the arbitration except that the costs imposed by the AAA shall be shared equally. The existence of a Dispute or arbitration proceeding shall not in and of itself constitute cause for termination of this Agreement. During an arbitration proceeding, each party shall continue to perform its obligations under this Agreement pending the decision of the arbitrator.

ARTICLE X
TERM AND TERMINATION

10.1. Term. This Agreement shall have an initial term of three (3) year(s), commencing on the Effective Date. Thereafter, this Agreement shall automatically renew for terms of one (1) year each. Notwithstanding the foregoing, this Agreement may terminate in accordance with the Termination sections below.

10.2. Termination of Agreement. This Agreement may be terminated under any of the following circumstances:

A. By either party upon one hundred eighty (180) days prior written notice effective at the end of the initial term or at the end of any renewal term;

B. By either party upon ninety (90) days prior written notice if the other party is in material breach of this Agreement, except that such termination shall not take place if the breach is cured within sixty (60) days following the written notice;

C. By MCO upon ninety (90) days prior written notice to Provider without cause;

D. Immediately upon written notice by MCO if there is imminent harm to patient health or fraud or malfeasance is suspected;

E. Immediately upon written notice by either party if the other party becomes insolvent or has bankruptcy proceedings initiated against it;

F. Immediately upon written notice by Provider if MCO loses, relinquishes, or has materially affected its certificate of authority to operate as a managed care organization; or

G. Immediately upon written notice by MCO if Provider fails to adhere to MCO's credentialing criteria, including, but not limited to, if Provider (1) loses, relinquishes, or has materially affected its license to provide Covered Services in the State, (2) fails to comply with the insurance requirements set forth in this Agreement; or (3) is convicted of a criminal offense related to involvement in any Medicare or Medicaid program or has been terminated, suspended, barred, voluntarily withdrawn as part of a settlement agreement, or otherwise excluded from any Medicare or Medicaid program.

10.3. Rights and Obligations Upon Termination. Upon termination, the rights of each party hereunder shall terminate, provided, however, that such action shall not release the Provider or MCO of their obligations with respect to: (a) payments accrued to Provider prior to termination; (b) Provider's agreement not to seek compensation from Covered Persons for Covered Services prior to termination; and (c) completion of treatment of Covered Persons who are receiving care until continuation of the Covered Person's care can be arranged by MCO as determined by the Medical Director or as required by applicable law or the Payor Contract. Services provided during continuation of care shall be reimbursed in accordance with the terms of this Agreement.

10.4. Survival of Obligations. Any obligations that cannot be fully performed prior to the termination of this Agreement including, but not limited to, obligations in the following provisions set forth in this Section, shall survive the termination of this Agreement: Section 3.12 (Disparagement Prohibition); Article IV (Compliance With Law); Section 5.4 (Covered Person Hold Harmless); Article VI (Records/Inspection); Article VII (Insurance); Article VIII (Indemnification); Article IX (Dispute Resolution); Section 10.3 (Rights and Obligations Upon Termination).

ARTICLE XI
MISCELLANEOUS

11.1. Relationship of Parties. The relationship among the parties is that of independent contractors. None of the provisions of this Agreement are intended to create, or to be construed as creating, any agency, partnership, joint venture, employee-employer, or other relationship.

11.2. Conflicts Between Certain Documents. If there is any conflict between this Agreement hereto and the Provider Manual, this Agreement shall control. In the event of any conflict, however, between this Agreement and any Attachment hereto, the Attachment shall be controlling as to the product described in that Attachment. In the event of any conflicts between this Agreement, or any Attachment hereto, and the applicable Payor Contract with respect to what services constitute Covered Services, the Payor Contract shall control.

11.3. Assignment; Delegation of Duties. This Agreement is intended to secure the services of and be personal to Provider, and shall not be assigned, sublet, delegated or transferred by Provider without the prior written consent of MCO.

11.4. Headings. The headings of the sections of this Agreement are inserted merely for the purpose of convenience and do not, expressly or by implication, limit, define, or extend the specific terms of the section so designated.

11.5. Governing Law. All matters affecting the interpretation of this Agreement and the rights and obligations of the parties hereto shall be governed by and construed in accordance with applicable federal and State laws.

11.6. Third Party Beneficiary. Except as specifically provided herein, the terms and conditions of this Agreement shall be for the sole and exclusive benefit of Provider and MCO. Nothing herein, express or implied, is intended to be construed or deemed to create any rights or remedies in any third party.

11.7. Amendment. This Agreement, including all Attachments, may be amended at any time by mutual written agreement of the parties. This Agreement and any of its Attachments may also be amended by MCO furnishing Provider with any proposed amendments. Unless Provider objects in writing to such amendment during the thirty (30) day notice, Provider shall be deemed to have accepted the amendment. Notwithstanding the foregoing, this Agreement shall be automatically amended as necessary to comply with any applicable State or federal law or regulation and applicable provision of the Payor Contract.

11.8. Entire Agreement. This Agreement, its Attachments, and the Provider Manual contain all the terms and conditions agreed upon by the parties and supersede all other agreements, oral or otherwise, of the parties hereto, regarding the subject matter of this Agreement.

11.9. Severability. The invalidity or unenforceability of any terms or provisions hereof shall in no way affect the validity or enforceability of any other terms or provisions.

11.10. Waiver. The waiver by either party of the violation of any provision or obligation of this Agreement shall not constitute the waiver of any subsequent violation of the same or other provision or obligation.

11.11. Notices. Any notice required to be given pursuant to the terms and provisions hereof shall be in writing and shall be sent by certified mail, return receipt requested, postage prepaid, or by recognized courier service, addressed as follows:

To MCO at:	To Provider at:
Attn: President	Attn: Cochise County Health Department
Bridgeway Health Solutions, L.L.C.	Cochise County Health Department
1501 W.Fountainhead Pkwy, Ste 295	1415 Melody Lane Bldg A
Tempe AZ 85282	Bisbee, AZ 85603

or to such other address as either party may designate in writing.

11.12. Force Majeure. Neither party shall be liable or deemed to be in default for any delay or failure to perform any act under this Agreement resulting, directly or indirectly, from acts of God, civil or military authority, acts of public enemy, war, accidents, fires, explosions, earthquake, flood, strikes or other work stoppages by either party's employees, or any other similar cause beyond the reasonable control of such party.

11.13. Confidentiality. Neither party shall disclose the substance of this Agreement nor any information acquired from the other party during the course of or pursuant to this Agreement to any third party, unless required by law. Provider acknowledges and agrees

that all information relating to MCO's programs, policies, protocols and procedures is proprietary information and further agrees not to disclose such information to any person or entity without MCO's express written consent.

11.14. Authority. The parties whose signatures are set forth below represent and warrant that they are duly empowered to execute this Agreement.

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

IN WITNESS WHEREOF, the parties hereto have executed this Agreement effective as of the date first above written.

MCO:	**Provider:**
Bridgeway Health Solutions, L.L.C.	**Cochise County Health Department**
Authorized Signature	Authorized Signature
_____	_____
Printed Name: Paul D. Barnes, Ph.D.	Printed Name:
Title: President and CEO	Title:
Signature Date:	Signature Date:
Effective Date of Agreement: (To be completed by MCO only)	Tax Identification Number: 866000398
	National Provider Identifier: 1215968250
	State Medicaid Number: 062802

ANCILLARY SERVICES PROVIDER AGREEMENT DETERMINATION

Re: Ancillary Services Provider Agreement to provide between; between the Cochise Health & Social Services and the Bridgeway Health Solutions, LLC (MCO).

The attached agreement, which is an agreement between public agencies, has been reviewed pursuant to A.R.S. §11-952 on behalf of the Cochise County Health Department by the undersigned Deputy County Attorney who has determined that it is in proper form and is within the powers and authority granted under the laws of the State of Arizona.

Approved as to form this 2nd day of October, 2014.

EDWARD G. RHEINHEIMER
Cochise County Attorney

By: _____
Terry Bannon
Deputy County Attorney

ATTACHMENT A

MEDICAID PRODUCT ATTACHMENT

This Medicaid Product Attachment (the "***Product Attachment***") is incorporated into the Ancillary Services Provider Agreement (the "***Agreement***") entered into by and between Cochise County Health Department (referred to herein as "***Subcontractor***") and Bridgeway Health Solutions, L.L.C. (referred to herein as "***Contractor***").

ARTICLE I
GENERAL

1.1 **Subcontractor Acknowledgement**. Subcontractor acknowledges that Contractor has contracted with the Arizona Health Care Cost Containment System Administration ("***AHCCCS***" or "***System***") to arrange for the provision of medical services to Covered Persons under the Medicaid program ("***Medicaid Contract***"). This Attachment supplements the Agreement entered into between Contractor and Subcontractor by setting forth the parties' rights and responsibilities relating to the provision of Covered Services to Covered Persons as pertaining to the Medicaid program. If Subcontractor is a physician group, including, but not limited to, either a physician organization or an independent physician association, Subcontractor agrees to bind its employed or contracted physicians and other health care professionals to the applicable terms and conditions of this Product Attachment, pursuant to the terms of the Agreement.

1.2 **Order of Precedence**. In the event of a conflict between the terms and conditions of the Agreement and the terms and conditions of this Product Attachment, this Product Attachment shall govern.

1.3 **Compliance with Laws and Policies**. Notwithstanding any provisions set forth in this Attachment, to the extent applicable, Subcontractor shall comply with all duties and obligations under the Agreement, the Provider Manual and this Product Attachment. Subcontractor agrees and understands that Covered Services shall be provided in accordance with the Medicaid Contract, the Provider Manual, any applicable State Medicaid Handbooks, and all applicable State and federal laws and regulations. To the extent Subcontractor is unclear about Subcontractor's duties and obligations, Subcontractor shall request clarification from Contractor.

ARTICLE II
DEFINITIONS

The definitions listed below will supersede any meanings contained in the Agreement.

2.1 ***ADHS*** shall mean the Arizona Department of Health Services, the state agency mandated to serve the public health needs of all Arizona citizens.

2.2 ***AMPM*** shall mean the AHCCCS Medical Policy Manual available on the AHCCCS website at www.azahcccs.gov.

2.3 ***ARS*** shall mean Arizona Revised Statutes.

2.4 ***Clean Claim*** shall mean a claim that may be processed without obtaining additional information from the provider of service or from a third party, but does not include a claim under investigation for fraud or abuse or under review for Medical Necessity.

2.5 ***Covered Services*** shall mean health care services to be delivered by Contractor, which are designated in Section D of the Contractor's contract with AHCCCS; AHCCCS Rules R9-22, Article 2, and R9-31, Article 2, and the AMPM [42 CFR 438.210(a)(4)].

2.6 ***Emergency Medical Service*** or ***Emergency Care*** shall mean inpatient and outpatient Covered Services provided after the sudden onset of an Emergency Medical Condition. These services must be furnished by a qualified provider, and must be necessary to evaluate or stabilize the Emergency Medical Condition [42 CFR 438.114(a)].

2.7 ***State*** shall mean the State of Arizona.

2.8 ***Subcontract*** means any contract between the Contractor and a third party for the performance of any or all services or requirements specified under the Contractor's contract with AHCCCS.

2.9 ***Subcontractor*** means any third party with a contract with the Contractor for the provision of any or all services or requirements specified under the Contractor's contract with AHCCCS.

ARTICLE III
AHCCCS MINIMUM SUBCONTRACTOR OBLIGATIONS

3.1 **Assignment and Delegation of Rights and Responsibilities**. No payment due the Subcontractor under this subcontract may be assigned without the prior approval of the Contractor. No assignment or delegation of the duties of this subcontract shall be valid unless prior written approval is received from the Contractor. (AAC R2-7-305)

3.2 **Awards of Other Subcontracts**. AHCCCS and/or the Contractor may undertake or award other contracts for additional or related work to the work performed by the Subcontractor and the Subcontractor shall fully cooperate with such other contractors, subcontractors or State employees. The Subcontractor shall not commit or permit any act which will interfere with the performance of work by any other contractor, subcontractor or State employee. (AAC R2-7-308)

3.3 **Certification of Compliance – Anti-Kickback and Laboratory Testing**. By signing this subcontract, the Subcontractor certifies that it has not engaged in any violation of the Medicare Anti-Kickback statute (42 USC §§1320a-7b) or the "Stark I" and "Stark II" laws governing related-entity referrals (PL 101-239 and PL 101-432) and compensation

there from. If the Subcontractor provides laboratory testing, it certifies that it has complied with 42 CFR §411.361 and has sent to AHCCCS simultaneous copies of the information required by that rule to be sent to the Centers for Medicare and Medicaid Services. (42 USC §§1320a-7b; PL 101-239 and PL 101-432; 42 CFR §411.361)

3.4 **Certification of Truthfulness of Representation**. By signing this subcontract, the Subcontractor certifies that all representations set forth herein are true to the best of its knowledge.

3.5 **Clinical Laboratory Improvement Amendments of 1988**. The Clinical Laboratory Improvement Amendment (CLIA) of 1988 requires laboratories and other facilities that test human specimens to obtain either a CLIA Waiver or CLIA Certificate in order to obtain reimbursement from the Medicare and Medicaid (AHCCCS) programs. In addition, they must meet all the requirements of 42 CFR 493, Subpart A.

To comply with these requirements, AHCCCS requires all clinical laboratories to provide verification of CLIA Licensure or Certificate of Waiver during the provider registration process. Failure to do so shall result in either a termination of an active provider ID number or denial of initial registration. These requirements apply to all clinical laboratories.

Pass-through billing or other similar activities with the intent of avoiding the above requirements are prohibited. The Contractor may not reimburse providers who do not comply with the above requirements (CLIA of 1988; 42 CFR 493, Subpart A).

3.6 **Compliance with AHCCCS Rules Relating to Audit and Inspection**. The Subcontractor shall comply with all applicable AHCCCS Rules and Audit Guide relating to the audit of the Subcontractor's records and the inspection of the Subcontractor's facilities. If the Subcontractor is an inpatient facility, the Subcontractor shall file uniform reports and Title XVIII and Title XIX cost reports with AHCCCS (ARS 41-2548; 45 CFR 74.48 (d)).

3.7 **Compliance with Laws and Other Requirements**. The Subcontractor shall comply with all federal, State and local laws, rules, regulations, standards and executive orders governing performance of duties under this subcontract, without limitation to those designated within this subcontract [42 CFR 434.70] [42 CFR 438.6(l)].

3.8 **Confidentiality Requirement**. The Subcontractor shall safeguard confidential information in accordance with federal and State laws and regulations, including but not limited to, 42 CFR Part 431, Subpart F, ARS §36-107, 36-2903 (for Acute), 36-2932 for ALTCS), 41-1959 and 46-135, AHCCCS Rules and the Health Insurance Portability and Accountability Act (Public Law 107-191 Statues 1936), 45 CFR Parts 160 and 164, and AHCCCS Rules.

3.9 **Conflict in Interpretation of Provisions**. In the event of any conflict in interpretation between provisions of this subcontract and the AHCCCS Minimum Subcontract Provisions, the latter shall take precedence.

3.10 **Contract Claims and Disputes**. Contract claims and disputes arising under A.R.S. Title 36, Chapter 29 shall be adjudicated in accordance with AHCCCS Rules, ARS §36-2901 et seq. (for Acute) and ARS §36-2931 et seq. (for ALTCS).

3.11 **Encounter Data Requirement**. If the Subcontractor does not bill the Contractor (e.g., Subcontractor is capitated), the Subcontractor shall submit encounter data to the Contractor in a form acceptable to AHCCCS.

3.12 **Evaluation of Quality, Appropriateness, or Timeliness of Services**. AHCCCS or the U.S. Department of Health and Human Services may evaluate, through inspection or other means, the quality, appropriateness or timeliness of services performed under this subcontract.

3.13 **Fraud and Abuse**. If the Subcontractor discovers, or is made aware, that an incident of suspected fraud or abuse has occurred, the Subcontractor shall report the incident to the prime Contractor as well as to AHCCCS, Office of the Inspector General (OIG). All incidents of potential fraud should be reported to the OIG.

3.14 **General Indemnification**. The parties to this contract agree that AHCCCS shall be indemnified and held harmless by the Contractor and Subcontractor for the vicarious liability of AHCCCS as a result of entering into this contract. However, the parties further agree that AHCCCS shall be responsible for its own negligence. Each party to this contract is responsible for its own negligence.

3.15 **Insurance**. [This provision applies only if the Subcontractor provides services directly to AHCCCS members]

The Subcontractor shall maintain for the duration of this subcontract a policy or policies of professional liability insurance, comprehensive general liability insurance and automobile liability insurance in amounts that meet Contractor's requirements. The Subcontractor agrees that any insurance protection required by this subcontract, or otherwise obtained by the Subcontractor, shall not limit the responsibility of Subcontractor to indemnify, keep and save harmless and defend the State and AHCCCS, their agents, officers and employees as provided herein. Furthermore, the Subcontractor shall be fully responsible for all tax obligations, Worker's Compensation Insurance, and all other applicable insurance coverage, for itself and its employees, and AHCCCS shall have no responsibility or liability for any such taxes or insurance coverage. (45 CFR Part 74) The requirement for Worker's Compensation Insurance doesn't apply when a Subcontractor is exempt under ARS 23-901, and when such Subcontractor executes the appropriate waiver (Sole Proprietor/Independent Contractor) form.

3.16 **Limitations on Billing and Collection Practices**. Except as provided in federal and State law and regulations, the Subcontractor shall not bill, or attempt to collect payment from a person who was AHCCCS eligible at the time the Covered Service(s) were rendered, or from the financially responsible relative or representative for Covered Services that were paid or could have been paid by the System.

3.17 **Maintenance Of Requirements To Do Business And Provide Services**. The Subcontractor shall be registered with AHCCCS and shall obtain and maintain all licenses, permits and authority necessary to do business and render service under this subcontract and, where applicable, shall comply with all laws regarding safety, unemployment insurance, disability insurance and worker's compensation.

3.18 **Non-Discrimination Requirements**. The Subcontractor shall comply with State Executive Order No. 99-4, which mandates that all persons, regardless of race, color, religion, gender, national origin or political affiliation, shall have equal access to employment opportunities, and all other applicable federal and State laws, rules and regulations, including the Americans with Disabilities Act and Title VI. The Subcontractor shall take positive action to ensure that applicants for employment, employees, and persons to whom it provides service are not discriminated against due to race, creed, color, religion, sex, national origin or disability. (Federal regulations, State Executive order # 99-4)

3.19 **Prior Authorization and Utilization Management**. The Contractor and Subcontractor shall develop, maintain and use a system for prior authorization and utilization review that is consistent with AHCCCS Rules and the Contractor's policies.

3.20 **Records Retention**. The Subcontractor shall maintain books and records relating to covered services and expenditures including reports to AHCCCS and working papers used in the preparation of reports to AHCCCS. The Subcontractor shall comply with all specifications for record keeping established by AHCCCS. All books and records shall be maintained to the extent and in such detail as required by AHCCCS Rules and policies. Records shall include but not be limited to financial statements, records relating to the quality of care, medical records, prescription files and other records specified by AHCCCS.

The Subcontractor agrees to make available at its office at all reasonable times during the term of this contract and the period set forth in the following paragraphs, any of its records for inspection, audit or reproduction by any authorized representative of AHCCCS, State or Federal government.

The Subcontractor shall preserve and make available all records for a period of five years from the date of final payment under this contract unless a longer period of time is required by law. For retention of patient medical records, the subcontractor shall ensure compliance with A.R.S. §12-2297 which provides, in part, that a health care provider shall retain patient medical records according to the following:

1. If the patient is an adult, the provider shall retain the patient medical records for at least six years after the last date the adult patient received medical or health care services from that provider.

2. If the patient is under 18 years of age, the provider shall retain the patient medical records either for at least three years after the child's eighteenth birthday or for at least six years after the last date the child received medical or health care services from that provider, whichever date occurs later.

In addition, the Subcontractor shall comply with the record retention periods specified in HIPAA laws and regulations, including, but not limited to, 45 CFR 164.530(j)(2).

If this contract is completely or partially terminated, the records relating to the work terminated shall be preserved and made available for a period of five years from the date of any such termination. Records which relate to grievances, disputes, litigation or the settlement of claims arising out of the performance of this contract, or costs and expenses of this contract to which exception has been taken by AHCCCS, shall be retained by the Subcontractor for a period of five years after the date of final disposition or resolution thereof unless a longer period of time is required by law. (45 CFR 74.53; 42 CFR 431.17; A.R.S. §41-2548)

3.21 **Severability**. If any provision of these standard subcontract terms and conditions is held invalid or unenforceable, the remaining provisions shall continue valid and enforceable to the full extent permitted by law.

3.22 **Standards of Conduct**. The subcontractor will perform services for members consistent with the proper and required practice of medicine and must adhere to the customary rules of ethics and conduct of its appropriate professional organization including, but not limited to, the American Medical Association and other national and state boards and associations or health care professionals to which they are subject to licensing, certification, and control.

3.23 **Subjection of Subcontract**. The terms of this subcontract shall be subject to the applicable material terms and conditions of the contract existing between the Contractor and AHCCCS for the provision of Covered Services.

3.24 **Termination of Subcontract**. AHCCCS may, by written notice to the Subcontractor, terminate this subcontract if it is found, after notice and hearing by the State, that gratuities in the form of entertainment, gifts, or otherwise were offered or given by the Subcontractor, or any agent or representative of the Subcontractor, to any officer or employee of the State with a view towards securing a contract or securing favorable treatment with respect to the awarding, amending or the making of any determinations with respect to the performance of the Subcontractor; provided, that the existence of the facts upon which the State makes such findings shall be in issue and may be reviewed in any competent court. If the subcontract is terminated under this section, unless the Contractor is a governmental agency, instrumentality or subdivision thereof, AHCCCS

shall be entitled to a penalty, in addition to any other damages to which it may be entitled by law, and to exemplary damages in the amount of three times the cost incurred by the Subcontractor in providing any such gratuities to any such officer or employee. (AAC R2-5-501; ARS 41-2616 C.; 42 CFR 434.6, a. (6))

3.25 **Voidability of Subcontract**. This subcontract is voidable and subject to immediate termination by AHCCCS upon the Subcontractor becoming insolvent or filing proceedings in bankruptcy or reorganization under the United States Code, or upon assignment or delegation of the subcontract without AHCCCS's prior written approval.

3.26 **Warranty of Services**. The Subcontractor, by execution of this subcontract, warrants that it has the ability, authority, skill, expertise and capacity to perform the services specified in this contract.

3.27 **Off-Shore Performance of Work Prohibited**. Due to security and identity protection concerns, direct services under this contract shall be performed within the borders of the United States. Any services that are described in the specifications or scope of work that directly serve the State of Arizona or its clients and may involve access to secure or sensitive data or personal client data or development or modification of software for the State shall be performed within the borders of the United States. Unless specifically stated otherwise in specifications, this definition does not apply to indirect or "overhead" services, redundant back-up services or services that are incidental to the performance of the contract. This provision applies to work performed by subcontractors at all tiers.

3.28 **Federal Immigration and Nationality Act**. The Subcontractor shall comply with all federal, State and local immigration laws and regulations relating to the immigration status of their employees during the term of the contract. Further, the Subcontractor shall flow down this requirement to all subcontractors utilized during the term of the contract. The State shall retain the right to perform random audits of Contractor and subcontractor records or to inspect papers of any employee thereof to ensure compliance. Should the State determine that the Contractor and/or any subcontractors be found noncompliant, the State may pursue all remedies allowed by law, including, but not limited to; suspension of work, termination of the contract for default and suspension and/or debarment of the Contractor.

Compliance with the Federal Immigration and Nationality Act (FINA) and All Other Federal Immigration Laws and Regulations related to Immigration Status of its Employees:

By entering into the Agreement, the subcontractor warrants compliance with the Federal Immigration and Nationality Act (FINA) and all other Federal immigration laws and regulations related to the immigration status of its employees. The subcontractor shall obtain statements from any of its subcontractors certifying compliance and shall furnish the statements to the Procurement Officer, upon request. These warranties shall remain in effect through the term of the Agreement. The subcontractor and its subcontractors shall also maintain Employment Eligibility Verification forms (I-9) as required by the U.S.

Department of Labor's Immigration and Control Act, for all employees performing work under the Contract. I-9 forms are available for download at USCIS.GOV

The State may request verification of compliance for any subcontractor or its subcontractor performing work under the Agreement. Should the Contractor suspect or find that the subcontractor or any of its subcontractors are not in compliance, the Contractor may pursue any and all remedies allowed by law, including, but not limited to: suspension of work, termination of the Agreement for default, and suspension and/or debarment of the subcontractor. All costs necessary to verify compliance are the responsibility of the subcontractor.

Compliance Requirements for A.R.S. 41-4401, Government Procurement: E-Verify Requirement:

The subcontractor warrants compliance with all Federal immigration laws and regulations relating to employees and warrants its compliance with Section A.R.S. 23-214, Subsection A. (That subsection reads: "After December 31, 2007, every employer, after hiring an employee, shall verify the employment eligibility of the employee through the B-Verify program.")

A breach of a warranty regarding compliance with immigration laws and regulations shall be deemed a material breach of the contract and the subcontractor may be subject to penalties up to and including termination of the contract.

Failure to comply with a State or Contractor audit process to randomly verify the employment records of subcontractors and any of its subcontractors shall be deemed a material breach of the contract and the subcontractor may be subject to penalties up to and including termination of the contract.

The State Agency and Contractor retains the legal right to inspect the papers of any employee who works on the contract to ensure that the contractor or subcontractor is complying with the warranty.

ARTICLE IV
ADDITIONAL SUBCONTRACTOR OBLIGATIONS

4.1 **Pediatric Immunizations and the Vaccines for Children Program**. If Subcontractor is acting as a primary care physician to Covered Persons under the age of nineteen (19), Subcontractor shall be registered with ADHS Vaccines for Children Program. Subcontractor shall comply with State law requiring the reporting of all immunizations. Subcontractor should access the Arizona State Immunization Information System ("ASIIS") to obtain complete, accurate immunization records.

4.2 **Medical Records**:

(a) If Subcontractor is a primary care physician, Subcontractor shall maintain medical records that: (i) are detailed and comprehensive; (ii) identify all medically

necessary services provided to Covered Persons, and all emergency services provided by noncontracting providers to Covered Persons; (iii) conform to professional medical standards and practices for documentation of medical diagnostic and treatment data; (iv) facilitate follow-up treatment; and (v) permit professional medical review and medical audit processes.

(b) If Subcontractor is a primary care physician Subcontractor shall in addition establish a medical record when information is received about a Covered Person. If Subcontractor has not seen the Covered Person, such information may be kept temporarily in an appropriately labeled file, in lieu of establishing a medical record, but must be associated with the Covered Person's medical record as soon as one is established.

(c) When a Covered Person changes primary care physicians, the Covered Person's medical records or copies of medical records must be forwarded to the new primary care physician within ten (10) business days from receipt of the request for transfer of the medical records. Within thirty (30) days following termination of the Agreement, Subcontractor shall forward to the primary care provider all medical records (or copies thereof) relating to Covered Persons assigned to the Subcontractor or for whom the Subcontrator has provided services.

(d) AHCCCS shall be afforded access to all Covered Persons' medical records whether electronic or paper within twenty (20) business days of receipt of request.

4.3 **Appointment Standards**. In accordance with requirements under the Medicaid Contract, Subcontractor shall adhere to the following appointment standards, subject to applicable federal and State law and regulations:

A. For primary care appointments, Subcontractor shall provide:
Emergency primary care appointments – same day of request
Urgent care primary care appointments – within 2 days of request
Routine care primary care appointments – within 21 days of request

B. For specialty referrals, Subcontractor shall provide:
Emergency appointments – within 24 hours of referral
Urgent care appointments – within 3 days of referral
Routine care appointments – within 45 days of referral

C. For dental appointments, Subcontractor shall provide:
Emergency appointments – within 24 hours of request
Urgent care appointments – within 3 days of request
Routine care appointments – within 45 days of request

D. For maternity care, Subcontractor shall provide initial prenatal care appointments for enrolled pregnant Covered Persons:
First trimester – within 14 days of request
Second trimester – within 7 days of request
Third trimester – within 3 days of request
High risk pregnancies – within 3 days of identification of high risk by the Contractor or maternity care provider, or immediately if an emergency exists.

For purposes of this section, "urgent" is defined as an acute, but not necessarily life-threatening condition which, if not attended to, could endanger the patient's health.

A Covered Person's wait time for a scheduled appointment at a primary care physician or specialist's office shall not exceed 45 minutes, except when the provider is unavailable due to an emergency.

If Subcontractor is a non-emergent transportation vendor, Subcontractor shall schedule the transportation so that the Covered Person arrives on time for the appointment, but no sooner than one hour before the appointment; does not have to wait more than one hour after calling for transportation after the conclusion of the appointment to be picked up; nor have to wait for more than one hour after conclusion of the treatment for transportation home; nor be picked up prior to the completion of treatment.

4.4 **Provider Registration**. Subcontractor shall register with AHCCCS as an approved service provider, and sign a Provider Participation Agreement if not already an AHCCCS registered provider. If eligible for a National Provider Identifier ("NPI"), Subcontractor shall include NPI on all claim submissions and subsequent encounters.

4.5 **Suspension or Debarment**. Subcontractor warrants that it is not debarred, suspended or otherwise excluded from federal procurement activity or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order 12549 [42 CFR 438.610 (a) and (b)].

4.6 **Reassignment**. Subcontractor agrees that it shall comply with the provider reimbursement terms relating to the proper reassignment of the right to claims payment and the billing of personally performed services set forth at AZ ADC R9-22-714 Subsections B, C and D.

4.7 **Continuation of Care**. In the event this Agreement is terminated for reasons other than the Subcontractor's medical incompetence or unprofessional conduct, if a Covered Person provides written request to Contractor to continue an active course of treatment with Subcontractor for a transitional period after the date of such termination, Subcontrator agrees to:

(a) Except for copayment, coinsurance or deductible amounts, continue to accept as payment in full reimbursement from the Contractor at the rates applicable before the beginning of the transitional period;

(b) Comply with the Contractor's quality assurance and utilization review requirements with respect to such continuing care, and provide Contractor with any necessary medical information related to such care;

(c) Comply with the Contractors' relevant policies and procedures, including, but not limited to, those relating to referrals, preauthorization, claims handling and treatment plan approval, with respect to such continuing care.

4.8 **Insolvency of Contractor.** In the event Contractor becomes insolvent during the term hereof, Subcontractor shall provide Covered Services to Covered Persons, at the same rates and subject to the same terms and conditions established in the Agreement and this Attachment, for the duration of the period after Contractor is declared insolvent, until the earliest of the following: i) the expiration of the period during which the Contractor is required to continue benefits as described in A.R.S. Sec. 20-1069(A); ii) a notification from the receiver, pursuant to A.R.S. Sec. 20-1069(F), or a determination by a court that the Contractor cannot provide adequate assurance it will be able to pay providers' claims for Covered Services that were rendered after the Contractor is declared insolvent; iii) a determination by a court that the Contractor is unable to pay providers' claims for Covered Services that were rendered after the Contractor is declared insolvent; iv) a determination by a court that continuation of the Agreement would constitute undue hardship to the Subcontractor; or v) a determination by a court that Contractor has satisfied its obligations to all Covered Persons.

4.9 **Subcontracts.** Subcontractor acknowledges and agrees that the following provisions, to the extent applicable, are addressed in the Agreement and/or this Attachment, in accordance with the requirements of the Medicaid Contract, and that Subcontractor shall comply with the same.

A. Full disclosure of the method and amount of compensation or other consideration to be received by the Subcontractor.

B. Subcontractor's name and address.

C. Identification of the population, to include patient capacity, to be covered by the Subcontractor.

D. The amount, duration and scope of medical services to be provided by the Subcontractor, for which compensation will be paid.

E. The term of the Agreement and this Attachment, including beginning and ending dates, methods of extension, termination and renegotiation.

F. The specific duties of the Subcontractor relating to coordination of benefits and determination of third-party liability.

G. Subcontractor's agreement to identify Medicare and other third-party liability coverage, and to seek such Medicare or third party liability payment, before submitting claims to the Contractor.

H. A description of the Subcontractor's patient, medical, dental and cost record keeping system.

I. Specification that the Subcontractor shall cooperate with Contractor's quality management/quality improvement programs, and comply with the utilization management and review procedures specified in 42 CFR Part 456, as specified in the AMPM.

J. A provision stating that a merger, reorganization or change in ownership of subcontractor providing ASO services to the Contractor shall require a contract amendment and prior approval of AHCCCS.

K. A provision that indicates that AHCCCS is responsible for enrollment, re-enrollment and dis-enrollment of the covered population.

L. A provision that the Subcontractor shall be fully responsible for all tax obligations, Worker's Compensation Insurance, and all other applicable insurance coverage obligations which arise under this Agreement and Attachment, for itself and its employees, and that AHCCCS shall have no responsibility or liability for any such taxes or insurance coverage.

M. A provision that the Subcontractor must obtain any necessary authorization from the Contractor or AHCCCS for services provided to eligible and/or enrolled Covered Persons.

N. A provision that the Subcontractor must comply with encounter reporting and claims submission requirements as described in the Agreement and this Attachment.

O. Provision(s) that allow the Contractor to suspend, deny, refuse to renew or terminate the Subcontractor in accordance with the terms of this contract and applicable law and regulation.

P. A provision that the Subcontractor may provide a Covered Person with factual information, but is prohibited from recommending or steering a Covered Person in his or her selection of a Medicaid managed care organization.

Q. A provision that compensation to individuals or entities that conduct utilization management and concurrent review activities is not structured so as to provide incentives for the individual or entity to deny, limit or discontinue medically necessary services to any enrollee (42 CFR 438.210(e)).

[SIGNATURE BLOCK FOLLOWS]

Contractor:

Bridgeway Health Solutions, L.L.C.

Authorized Signature

Printed Name: Paul D. Barnes, Ph.D.

Title: President and CEO

Signature Date:

Effective Date of Addendum:
(To be completed by Contractor only)

Subcontractor:

Cochise County Health Department

Authorized Signature

Printed Name:

Title:

Signature Date:

Tax Identification Number 866000398

National Provider Identifier: 1215968250

State Medicaid Number: 062802

EXHIBIT 1
COMPENSATION SCHEDULE - MEDICAID ACUTE AND ALTCS

Cochise County Health Department

For Covered Services provided to Covered Persons, Payor shall pay Provider the lesser of (i) Provider's Allowable Charges or (ii) one hundred percent (100%) of the Payor's maximum reimbursement fee schedule in effect on the date of service.

Additional Provisions:

1. Code Change Updates. Updates to billing-related codes (e.g., CPT, HCPCS, ICD-9, DRG, and revenue codes) shall become effective on the date ("Code Change Effective Date") that is the later of: (i) the first day of the month following thirty (30) days after publication by the governmental agency having authority over the applicable product of such governmental agency's acceptance of such code updates; or (ii) the effective date of such code updates, as determined by such governmental agency. Claims processed prior to the Code Change Effective Date shall not be reprocessed to reflect any code updates.

2. Fee Change Updates. Updates to such fee schedule shall become effective on the date ("Fee Change Effective Date") that is the later of: (i) the first day of the month following thirty (30) days after publication by the governmental agency having authority over the applicable product of such governmental agency's acceptance of such fee schedule updates; or (ii) the effective date of such fee schedule updates, as determined by such governmental agency. Claims processed prior to the Fee Change Effective Date shall not be reprocessed to reflect any updates to such fee schedule.

3. Payment under this Exhibit. All payments under this Exhibit are subject to the terms and conditions set forth in the Agreement and the Provider Manual.

Definitions:

1. **Allowable Charges** mean those Provider billed charges for services that qualify as Covered Services.

[SIGNATURE BLOCK FOLLOWS]

MCO:

Bridgeway Health Solutions, L.L.C.

Authorized Signature

Printed Name: Paul D. Barnes, Ph.D.

Title: President and CEO

Signature Date:

(To be completed by MCO only)

Provider:

Cochise County Health Department

Authorized Signature

Printed Name:

Title:

Signature Date:

Tax Identification Number: 866000398

National Provider Identifier: 1215968250

State Medicaid Number: 062802

ATTACHMENT B

MEDICARE ADVANTAGE AND CAPITATED FINANCIAL ALIGNMENT DEMONSTRATION ADDENDUM

This Medicare Advantage and Capitated Financial Alignment Demonstration Addendum ("Addendum") to the participating provider agreement ("Agreement") between Bridgeway Health Solutions, L.L.C. ("MCO") and Cochise County Health Department ("Provider") is made and entered into by and between MCO and Provider (each a "Party" and, collectively, the "Parties") effective as of _____, and supplements and amends the terms of the Agreement with respect to the provision of Covered Services to Covered Persons (as such terms are defined herein) enrolled in a Medicare Advantage plan ("MA Plan"), a Medicare Advantage – Prescription Drug plan ("MA-PD Plan"), and/or a Capitated Financial Alignment Demonstration plan ("Medicare-Medicaid Plan") (each such MA Plan, MA-PD Plan and Medicare-Medicaid Plan to be alternatively referred to herein as a "Medicare Plan," and collectively as the "Medicare Plans").

WHEREAS, MCO and Provider are bound by the Agreement, pursuant to which Provider has agreed to provide Covered Services to Covered Persons as specified therein;

WHEREAS, MCO and Provider mutually and respectively desire to amend the Agreement to include the provision of Covered Services as defined in this Addendum to Covered Persons who are enrolled in a Medicare Plan;

WHEREAS, Provider is certified to participate in the State Medicaid program, and, to the extent that Provider qualifies as a Medicare Provider or Supplier, Provider has signed a participation agreement with CMS and has been approved by CMS as meeting conditions for coverage of Provider's services;

WHEREAS, MCO or a Payor has been accepted by CMS, or has an application pending with CMS, to participate in the Medicare Advantage Program and/or a Capitated Financial Alignment Demonstration Program; and

WHEREAS, the Parties agree to supplement and amend the Agreement to include the requirements applicable to Participating Health Care Providers' participation under the Medicare Plans.

NOW THEREFORE, in consideration of the mutual promises of the Parties, the sufficiency of which is hereby acknowledged, the Parties agree as set forth below:

1. **DEFINITIONS.** The following terms, and any terms defined in the Agreement, shall have the specified meanings when capitalized in this Addendum. Capitalized terms not otherwise defined in this Addendum shall be defined as set forth in the Agreement.

1.1 Capitated Financial Alignment Demonstration Program means the program, created by Congress in the Affordable Care Act of 2010, to test new service delivery and payment models for people dually eligible for Medicare and Medicaid, including any regulations or CMS pronouncements and any future Attachments.

1.2 Clean Claim means a claim that has no defect, impropriety, lack of any required substantiating documentation – including the substantiating documentation needed to meet the requirements for encounter data – or particular circumstance requiring special treatment that prevents timely payment; and a claim that otherwise conforms to the Clean Claim requirements under original Medicare.

1.3 CMS means Centers for Medicare and Medicaid Services.

1.4 CMS Contract means the contract between MCO or a Payor and CMS, or among MCO or a Payor, CMS and the State, that governs the terms of MCO's or the Payor's participation in a Medicare Plan.

1.5 Covered Persons means those individuals who are enrolled in a Medicare Plan.

1.6 Covered Services means those services which are covered under a Medicare Plan.

1.7 HHS means the United States Department of Health and Human Services.

1.8 Medicare Advantage Program means the program created by Congress in the Medicare Modernization Act of 2003 to replace the Medicare+Choice Program established under Part C of Title XVIII of the Social Security Act, including any regulations or CMS pronouncements and any future Attachments.

1.9 State means one or more applicable state governmental agencies of the State of Arizona.

2. **COVERED SERVICES.** Provider shall furnish Covered Services to Covered Persons as set forth herein.

3. **SUBCONTRACTOR OBLIGATIONS.** To the extent that Provider executes a contract with any other person or entity that in any way relates to Provider's obligations under the Agreement or this Addendum, including any downstream entity, subcontractor or related entity, Provider shall require that such other person or entity assume the same obligations that Provider assumes under this Addendum.

4. **GOVERNMENT RIGHT TO INSPECT.** Provider agrees that HHS, the Comptroller General or their designees have the right to audit evaluate and inspect any pertinent information for any particular contract period, including, but not limited to, any books, contracts, computer or other systems, (including medical records and documentation of Provider relating to the CMS Contract through ten (10) years from the termination date of

this Addendum or from the date of completion of any audit, whichever is later. *42 C.F.R. § 422.504 (i)(2)(i) and (ii)*

Provider further agrees that HHS, the Comptroller General or their designees have the right to audit, evaluate and inspect any books, contracts, records, including medical records and documentation of the Provider, that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under this Addendum, or as the Secretary of HHS may deem necessary to enforce the CMS Contract. Provider shall cooperate with and shall assist and provide such information and documentation to such entities as requested. Provider shall retain, and agrees that this right to inspect, evaluate and audit shall extend for a period of ten (10) years following the termination date of this Addendum or completion of audit, whichever is later, unless (i) CMS determines that there is a special need to retain a particular record or group of records for a longer period and notifies the Payor at least 30 days before the normal disposition date; (ii) there has been a termination, dispute, or allegation of fraud or similar fault by the Payor, in which case the retention may be extended to six (6) years from the date of any resulting final resolution of the termination, dispute, fraud, or similar fault; or (iii) CMS determines that there is a reasonable possibility of fraud or similar fault, in which case CMS may inspect, evaluate, and audit at any time. This provision shall survive termination of this Addendum. To the extent that Provider executes a contract with any other person or entity that in any way relates to Provider's obligations under this Addendum, Provider shall require that such other person or entity assume the same obligations that Provider assumes under this Article IV. *42 C.F.R. § 422.504 (e)(2).*

5. **CONFIDENTIALITY AND ENROLLEE RECORD REQUIREMENTS.** Provider shall comply with all confidentiality and enrollee record accuracy requirements, including: (1) abiding by all federal and State laws regarding the confidentiality and disclosure of medical records or other health and enrollment information; (2) ensuring that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoena; (3) maintaining the records and information in an accurate and timely manner; and (4) ensuring timely access timely access by Covered Persons to the records and information that pertains to them. *42 C.F.R. §422.504(a)(13) and 422.118*

6. **HOLD HARMLESS.**

6.1 Provider hereby agrees that Covered Persons shall not be held liable for payment of any fees that are the legal obligation of the Payor. *42 C.F.R. §§422.504(i)(3)(i) and 422.504(g)(1)(i)*

6.2 With respect to MA Plans and MA-PD Plans, Provider hereby acknowledges and agrees that for Covered Persons eligible for both Medicare and Medicaid, such Covered Persons shall not be held liable for Medicare Part A and Part B cost-sharing when the State is responsible for paying such amounts. With respect to Medicare-Medicaid Plans, Provider hereby acknowledges and agrees that Covered Persons eligible for both Medicare and Medicaid shall not be held liable

for Medicare Part A and Part B cost-sharing; in addition, Medicare Parts A and B services must be provided at zero cost-sharing as part of the integrated package of benefits. *42 C.F.R. §§422.504(g)(1)(iii); March 29, 2012 CMS Issued Guidance*

With respect to all Medicare Plans, Provider will be informed of Medicare and Medicaid benefits and rules for Covered Persons eligible for Medicare and Medicaid. Provider may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the Covered Person under title XIX if such Covered Person were not enrolled with the Payor. Provider shall accept payment from the Payor as payment in full, or bill the appropriate State source. *42 C.F.R. §§422.504(i)(3)(i) and 422.504(g)(1)(iii)*

7. **COMPLIANCE WITH CMS CONTRACT.** Provider shall perform its obligations under this Addendum in a manner consistent with and in compliance with MCO's and Payor's contractual obligations under the CMS Contract. *42 C.F.R. §422.504(i)(3)(iii)*

8. **PROMPT PAYMENT.** The Payor shall pay, or arrange to pay, Provider for Covered Services rendered to Covered Persons in accordance with Exhibit 1 to this Addendum. Any Clean Claim, as defined in 42 C.F.R. § 422.500, shall be paid within thirty (30) days of receipt by MCO at such address as may be designated by MCO. *42 C.F.R. §422.520(b)(1) and (2)*

9. **COMPLIANCE WITH FEDERAL AND STATE LAWS.** MCO, Provider, Payor, and any related party or other contractor or subcontractor shall comply with all applicable laws, regulations and CMS and/or State instructions. *42 C.F.R. §422.504(i)(4)(v)*

10. **DELEGATION OF DUTIES.** In the event that MCO delegates to Provider any function or responsibility imposed pursuant to the State Contract, such delegation shall be subject to the applicable requirements set forth in 42 C.F.R. §§ 422.504(i)(4) and 423.505(i), as they may be amended over time. Any delegation by Provider of functions or responsibilities imposed pursuant to this Addendum shall be subject to the prior written approval of MCO and shall also be subject to the requirements set forth in 42 C.F.R. §§ 422.504(i)(4) and (5) and 423.505(i), as they may be amended over time.

10.1 Provider's delegated activities and reporting responsibilities, if any, are specified in the Delegated Credentialing Agreement or Delegated Services Agreement attached to this Agreement. If such attachment is not executed, no administrative functions shall be deemed as delegated.

10.2 CMS, MCO and the Payor reserve the right to revoke the delegation activities and reporting requirements or to specify other remedies in instances where CMS, MCO or the Payor determine that such parties have not performed satisfactorily.

10.3 The Payor will monitor the performance of the parties on an ongoing basis.

10.4 As specified in the attached Delegated Credentialing Agreement or Delegated Services Agreement to this Agreement, the credentials of medical professionals affiliated with Provider will be either reviewed by MCO, or the credentialing process will be reviewed and approved by MCO and MCO must audit the credentialing process on an ongoing basis.

10.5 If MCO or a Payor delegates the selection of providers, contractors, or subcontractors, MCO and the Payor retain the right to approve, suspend, or terminate any such arrangement.

42 C.F.R. 422.504(i)(4) and (5)

11. **SAFEGUARDING OF PRIVACY.** Provider shall comply with all federal and state laws regarding confidentiality and disclosure of medical records, or other health and enrollment information. Provider shall comply with MCO's and the Payor's policies and procedures with respect to the safeguarding of privacy of individually identifiable information relating to an Covered Person. *42 C.F.R. §§422.504(a)((13); 422.118*

12. **NON-DISCRIMINATION BASED ON HEALTH OR OTHER STATUS.** Provider shall not deny, limit, or condition coverage or the furnishing of health care services or benefits to Covered Persons based on any factor related to health status, including, but not limited to, medical condition (including mental as well as physical illness), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), race, ethnicity, national origin, religion, sex, age, sexual orientation, source of payment and mental or physical disability. *42 C.F.R. §422.110(a)*

13. **SERVICE AVAILABILITY.** Provider shall ensure that its hours of operation are convenient to Covered Persons and do not discriminate against Covered Persons; and that Covered Services are available twenty-four (24) hours a day, seven (7) days a week, when medically necessary. *42 C.F.R. §422.112(a)(7).*

14. **CULTURAL COMPETENCE.** Provider must provide all services in a culturally competent manner to all Covered Persons, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds. *42 C.F.R. §422.112(a)(8).*

15. **FOLLOW-UP CARE.** Provider shall ensure that Covered Persons are informed of specific health care needs that require follow-up and receive, as appropriate, training in self-care and other measures they may take to promote their own health. *42 C.F.R. §422.112(b)(5).*

16. **ADVANCE DIRECTIVES.** Provider shall comply with MCO's and the Payor's policies and procedures concerning advance directives. *42 C.F.R. §422. 128(b)(1)(ii)(E).*

17. **PROFESSIONALLY RECOGNIZED STANDARDS OF CARE.** Provider agrees to provide Covered Services under the Agreement to Medicare beneficiaries in a manner consistent with professionally recognized standards of health care. *42 C.F.R. §422.504(a)(3)(iii).*

18. **CONTINUATION OF BENEFITS.** Provider shall provide Covered Services as provided in the Agreement and this Addendum: (a) for all Covered Persons, for the duration of the contract period for which CMS payments have been made; and (b) for Covered Persons who are hospitalized on the date the CMS Contract terminates, or, in the event of an insolvency, through discharge. This continuation of benefits provision shall survive termination of this Addendum. *42 C.F.R. §§422.504(g)(2)(i); 422.504(g)(2)(ii); 422.504(g)(3)*

19. **PHYSICIAN INCENTIVE ARRANGEMENTS.** If Provider is a physician or physician group, neither the Payor nor MCO shall make any specific payment, directly or indirectly, to Provider as an inducement to reduce or limit medically necessary services furnished to any particular Covered Person. Indirect payments may include offerings of monetary value (such as stock options or waivers of debt) measured in the present or future. If the physician incentive plan places Provider at substantial financial risk (as determined under § 422.208(d)) for services that Provider does not furnish itself, Provider shall obtain and maintain either aggregate or per-patient stop-loss protection in accordance with § 422.208(f) of this section. MCO or the Payor must provide to CMS the information specified in §422.210 for all physician incentive plans (if any). *42 C.F.R. §422.208.*

20. **INFORMATION DISCLOSURES TO CMS.** Provider shall cooperate with MCO and the Payor in providing any information to CMS deemed necessary by CMS for the administration or evaluation of the Medicare program. *42 C.F.R. §422.504(f)(2).*

21. **NOTICE OF PROVIDER TERMINATIONS.** MCO shall make a good faith effort to provide written notice of a termination of a contracted provider at least 30 calendar days before the termination effective date to all Covered Persons who are patients seen on a regular basis by the provider whose contract is terminating, irrespective of whether the termination was for cause or without cause. If Provider is a primary care professional, all Covered Persons who are patients of that primary care professional must be notified. *42 C.F.R. §422.111(e).*

22. **RISK ADJUSTMENT DATA.** Provider shall provide to MCO complete and accurate risk adjustment data as required by CMS. *42 C.F.R. §422.310(d)(3), (4).* Upon MCO's or CMS's request, Provider shall submit a sample of medical records for the validation of risk adjustment data, as required by CMS. Provider acknowledges that penalties may apply for submission of false data. *42 C.F.R. §422.310(e).*

23. **COMPLIANCE WITH MCO POLICIES.** If Provider is a physician or physician group, Provider shall, or shall require the physician members of the group to, upon MCO 's request, consult with MCO regarding MCO's medical policy, quality improvement

programs and medical management procedures and ensure that the following standards are met: (a) practice guidelines and utilization management guidelines (i) are based on reasonable medical evidence or a consensus of health care professionals in the particular field; (ii) consider the needs of the enrolled population; (iii) are developed in consultation with contracting physicians; and (iv) are reviewed and updated periodically; (b) the guidelines are communicated to providers and, as appropriate, to Covered Persons; and (c) decisions with respect to utilization management, Covered Person education, coverage of services, and other areas in which the guidelines apply are consistent with the guidelines. *42 C.F.R. §422.202(b).* Provider shall comply with MCO's quality assurance and performance improvement programs.*§42 C.F.R. 422.504(a)(5).*

24. **WRITTEN NOTICE FOR REASON FOR SUSPENSION AND TERMINATION.** In the event MCO suspends or terminates this Addendum with respect to Provider or any physicians employed or contracted with Provider, MCO shall give Provider or such physician written notice of the following: (a) the reasons for the action, including, if relevant, the standards and profiling data used to evaluate the affected physician, and the numbers and mix of physicians needed by MCO, and (b) the affected physician's right to appeal the action and the process and timing for requesting a hearing. *42 C.F.R. §422.202(d)(1)*

25. **NOTICE OF WITHOUT CAUSE TERMINATION.** MCO and Provider must provide at least sixty (60) days written notice to each other before terminating this Addendum without cause. *42 C.F.R. §422.202(d)(4).*

26. **COMPLIANCE WITH FEDERAL LAWS AND REGULATIONS.** MCO and Provider agree to comply with (a) federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including, but not limited to, applicable provisions of federal criminal law, the False Claims Act (31 U.S.C. 3729 et. seq.), and the anti-kickback statute (section 1128B(b)) of the Act); and (b) HIPAA administrative simplification rules at 45 CFR parts 160, 162, and 164. *42 C.F.R. §422.504(h)(1).*

27. **EXCLUDED PRACTITIONERS.** Provider warrants to MCO and each Payor (a) that Provider and each of its owners, employees and contractors who provide health care, utilization review, medical social work, or any administrative services under or in connection with the Agreement (collectively "Personnel") (i) are not listed on the General Services Administration's Excluded Parties List System ("GSA List"), and (ii) are not suspended or excluded from participation in any federal health care programs, as defined under 42 U.S.C. § 1320a-7b(f), or any form of state Medicaid program (collectively, "Government Payor Programs"), and (b) that, to Provider's knowledge, there are no pending or threatened governmental investigations that may lead to suspension or exclusion of Provider or Personnel from Government Payor Programs or may cause for listing on the GSA List. *42 C.F.R. §422.752(a)(8).*

28. **COMPLIANCE WITH GRIEVANCE AND APPEALS REQUIREMENTS.** Provider shall cooperate and comply with all applicable State, federal MCO and Payor requirements regarding Covered Persons grievances and appeals, as well as enrollment

and disenrollment determinations, including the obligation to provide information (including medical records and other pertinent information) to MCO and Payor within the time frame required by regulation or, if not so required, reasonably requested for such purpose.

29. **OFFSHORE SUBCONTRACTORS.** Provider shall disclose to MCO in writing, within 30 days of signing an offshore contract, all offshore contractor information and an attestation for each such offshore contractor, in a format required or permitted by CMS. *Health Plan Management System memos 7/23/2007, 9/20/2007, and 8/26/2008.*

30. **SCOPE AND CONFLICTS.** Nothing in this Addendum shall be held to vary, alter, waive or extend any of the terms, conditions, agreements or limitations of the Agreement, including the Provider Manual, except as stated in this Addendum. In the event of any inconsistencies between this Addendum and any provision of the Agreement in connection with Provider's provision of Covered Services to Covered Persons, the provisions of this Addendum shall govern. In the event that any provision of this Addendum conflicts with the provisions of any statute or regulation applicable to MCO, the provisions of the statute or regulation shall have full force and effect.

31. **TERMINATION.** This Addendum shall terminate upon the termination of the Agreement and under the same terms and conditions specified in the Agreement. The Addendum may be further terminated by MCO immediately upon written notice to the Provider if a CMS Contract is terminated, or if Provider is listed on the GSA List or is suspended or excluded from participation in any federal health care programs, as defined under 42 U.S.C. § 1320a-7b(f), or any form of state Medicaid program.

MCO:	**Provider:**
Bridgeway Health Solutions, L.L.C.	**Cochise County Health Department**
Authorized Signature	Authorized Signature
Printed Name: Paul D. Barnes, Ph.D.	Printed Name:
Title: President and CEO	Title:
Signature Date:	Signature Date:
	Tax Identification Number: 866000398
	National Provider Identifier: 1215968250
	Medicare Number:

EXHIBIT 2
COMPENSATION SCHEDULE - MEDICARE

For Covered Services provided to Covered Persons who are eligible for Medicare and enrolled in a Bridgeway Health Solutions, L.L.C. Medicare Plan that may include coverage for both Medicare and Medicaid Covered Services, Payor shall pay Provider as follows:

Where Payor is the Payor for both Medicare Covered Services and Medicaid Covered Services:

- For Covered Services that are Medicare Covered Services and Medicaid Covered Services, Payor shall pay Provider the lesser of: (i) Provider's Allowable Charges; or (ii) Payor's maximum reimbursement schedule, which shall be the amount payable by Medicare, not including Medicare coinsurance or deductibles, as primary coverage based on the Medicare fee schedule in effect on the date of service, plus the amount payable by Medicaid as a secondary coverage based on the Medicaid fee schedule in effect on the date of service.
- For Covered Services that are Medicare Covered Services and are not Medicaid Covered Services, Payor shall pay Provider the lesser of: (i) Provider's Allowable Charges; or (ii) Payor's maximum reimbursement schedule, which shall be one hundred percent (100%) of the Medicare fee schedule in effect on the date of service.
- For Covered Services that are Medicaid Covered Services and are not Medicare Covered Services, Payor shall pay Provider the lesser of: (i) Provider's Allowable Charges; or (ii) Payor's maximum reimbursement schedule, which shall be one hundred percent (100%) of the Medicaid fee schedule in effect on the date of service.

Where Payor is only the Payor for Medicare Covered Services:

- For Covered Services that are Medicare Covered Services and Medicaid Covered Services, Payor shall pay Provider the lesser of: (i) Provider's Allowable Charges; or (ii) Payor's maximum reimbursement schedule, which shall be the amount payable by Medicare, not including Medicare coinsurance or deductibles, as primary coverage based on the Medicare fee schedule in effect on the date of service.
- For Covered Services that are Medicare Covered Services and are not Medicaid Covered Services, Payor shall pay Provider the lesser of: (i) Provider's Allowable Charges; or (ii) Payor's maximum reimbursement schedule, which shall be one hundred percent (100%) of the Medicare fee schedule in effect on the date of service.

Additional Provisions:

1. Code Change Updates. Updates to billing-related codes (e.g., CPT, HCPCS, ICD-9, DRG, and revenue codes) shall become effective on the date ("Code Change Effective Date") that is the later of: (i) the first day of the month following thirty (30) days after publication by the governmental agency having authority over the applicable product of such governmental agency's acceptance of such code updates; or (ii) the effective date of such code updates, as determined by such governmental agency. Claims processed prior to the Code Change Effective Date shall not be reprocessed to reflect any code updates.

2. Fee Change Updates. Updates to such fee schedule shall become effective on the date ("Fee Change Effective Date") that is the later of: (i) the first day of the month following thirty (30) days after publication by the governmental agency having authority over the applicable product of such governmental agency's acceptance of such fee schedule updates; or (ii) the effective date of such fee schedule updates, as determined by such governmental agency. Claims processed prior to the Fee Change Effective Date shall not be reprocessed to reflect any updates to such fee schedule.

3. Payment under this Exhibit. All payments under this Exhibit are subject to the terms and conditions set forth in the Agreement, the Provider Manual and the Billing Manual.

Definitions:

1. **Allowable Charges** means those Provider billed charges for services that qualify as Covered Services.

MCO:	**Provider:**
Bridgeway Health Solutions, L.L.C.	**Cochise County Health Department**
Authorized Signature	Authorized Signature
Printed Name: Paul D. Barnes, Ph.D.	Printed Name:
Title: President and CEO	Title:
Signature Date:	Signature Date:
	Tax Identification Number: 866000398
	National Provider Identifier: 1215968250