MISSISSIPPI Physicians Care NETWORK Change Networks. Not Doctors.

Dear Provider,

Thank you for your interest in joining the Mississippi Physicians Care Network (MPCN).

We proudly serve over 500,000 lives across the state, offering a fully credentialed and comprehensive network of healthcare providers to third-party administrators and to insurance companies alike.

Additionally, we work with governmental programs offering providers the option to participate in 15 different products.

Participation is OPTIONAL. If you choose not to participate in the governmental products, you will still be a member in the MPCN Commercial Network.

To enroll in the MPCN network, please complete and submit the following:

Numbers 1-5 below are REQUIRED documents for participation.

1. New Enrollment Checklist
2. MPCN Provider Registration Form
3. Mississippi Participating Physician Application
4. MPCN Disclosure of Ownership and Control Interest Statement
5. MPCN Agreement

Numbers 6–15 below are optional products. You must actively OPT IN to each one, except for Shared Health, which requires an OPT OUT.

6. Molina MississippiCAN, Molina Marketplace, Molina CHIP, and Molina Medicare Advantage D-SNP (All Molina Products are included on one attachment – You only need to fill out page 2 of the Molina Agreement)
7. Magnolia MississippiCAN
8. Magnolia Ambetter
9. Magnolia CHIP
10. WellCare Medicare Advantage
11. Primewell (Vantage) Medicare Advantage and Primewell (Vantage) Exchange (Both Primewell/Vantage Products are included on one attachment)
12. Shared Health OPT OUT form –
    * Note: To decline participation in Shared Health, you must opt out.
13. American Health Plan form
14. Healthy Mississippi (Qualexa)
15. TrueCare MSCAN and TrueCare CHIP

MPCN providers are offered the option to opt-in or opt-out of select products outside of MPCN's commercial network as listed on the Application Checklist.

Send your completed application, optional agreements, and application fee to:

MPCN – New Enrollment
P.O. Box 1530, Ridgeland, MS 39158-1530
or email to mlafleur@mpcn-ms.com

Incomplete applications will remain pending until all forms are received.

MISSISSIPPI Physicians Care NETWORK **Change Networks. Not Doctors.**

New Enrollment Checklist (Physician)

- ☐ **$75.00 Application/Initial Credentialing Fee**
  - ***Please note there is an annual membership fee of $75.00***
- ☐ **MPCN Provider Registration Form**
- ☐ Completed MS Participating Physician Application
  - Physician Signature - Section C. Certification (pg. 10)
  - Physician Signature - Section D. Attestation Questions (pg. 11)
  - Physician Signature – Section E. Release/Acknowledgments (pg. 12)
- ☐ **Signed MPCN Physician Agreement**
- ☐ **Current State Medical License Copy**
- ☐ **Board Certification Certificate Copy**
- ☐ **Federal DEA Certificate Copy** (if applicable)
- ☐ **CLIA Certificate if applicable**
- ☐ **Malpractice Policy Document/COI** – Must include policy number, coverage amount, expiration date, carrier address. Must not expire within (3) months.
- ☐ **Curriculum Vitae** or Documentation showing past (5) year's continuous education & practice
  - Must include month/year dates of employment/training
  - (6) Month or greater gaps in training or employment must be documented
- ☐ **ECFMG** (For foreign medical graduates licensed after 1986)
- ☐ **W-9**
- ☐ **Verification of NPI** number from NPPES NPI Registry
- ☐ **Disclosure of Ownership form**

---------- **Optional Product Opt-in/Opt-out Amendments to MPCN Contract** ----------

- **Magnolia MississippiCAN –** Signed Product Amendment Required
- **Magnolia Ambetter** – Signed Product Amendment Required
- **Magnolia CHIP** - Signed Product Amendment Required
- **Molina Healthcare** – Signed Product Amendment Required
  - Sign for each Molina product(s) you want to participate in
- **WellCare Medicare Advantage** – Signed Product Amendment Required
- **Primewell Medicare Advantage & Primewell Exchange** – Signed Amendment Required
- **American Health Plan –** Signed Product Amendment Required
- **Shared Health Mississippi DSNP** – **Opt-Out** only - Written notice to MPCN Required.
- **Healthy MS (Qualexa) -** Medicare Advantage Signed Product Amendment Required
- **TrueCare** - MSCAN & CHIP - Signed Product Amendment Required

MISSISSIPPI Physicians Care NETWORK **Change Networks. Not Doctors**.

MPCN Provider Registration/Update Form

Section 1: Current Information (Required for all updates)

Please attach W9 for all Tax ID and Group NPI updates

Practitioner Name:_____

Practitioner Individual NPI:_____

Individual Medicaid ID:_____ Individual Medicare ID: _____

Specialty:_____ PCP: ◯ Yes or ◯ No

Credentialing/Office Manager Name:_____

Email: _____ Phone:_____

Credentialing address:_____

Section 2: Type of Update – Check All that Apply

☐ Practitioner Name Change
☐ Practice Location Add/Update
☐ Billing Change
☐ Location Termination
☐ Tax ID/GNPI Addition (W-9 Required)
☐ Other Changes

Effective Date of Change: _____

Section 3: Practitioner Name Change – Attach updated Medical License & supporting documents

New Name: _____
Last, First Middle Suffix

Section 4: Location Term

Term Address: _____
City, State Zip code

Tax ID of termed Address_____

Mississippi Physicians Care Network
PO Box 1530, Ridgeland MS 39158
Phone: 601-605-4756 Fax: 601-605-4753

MISSISSIPPI Physicians Care NETWORK **Change Networks. Not Doctors**.

Section 5: Location Addition/Update

☐ Add New Location	☐ Update Existing Location

Provider Name (as listed on attached W-9) _____

Clinic DBA Name: _____

Tax ID_____ Group NPI_____

Office Phone_____ Office Fax_____

Physical Address_____

_____

Billing Address_____

_____

Mailing Address_____

_____

Additional Locations: Please complete for each physical location. Make copies if necessary.

Provider Name (as listed on W-9)_____

Clinic DBA Name: _____

Tax ID_____ Group NPI_____

Office Phone_____ Office Fax_____

Physical Address_____

_____

Mailing Address_____

_____

Billing Address_____

_____

Mississippi Physicians Care Network
PO Box 1530, Ridgeland MS 39158
Phone: 601-605-4756 Fax: 601-605-4753

Please check one:

☐ Original Application

☐ Reappointment

Mississippi Participating Physician Application

This application is submitted to _____, herein, this Managed Care Entity [1].

SECTION A.

Practice, Educational, Licensure and Work History Information

I. INSTRUCTIONS

This form should be typed or legibly printed in black ink. If more space is needed than provided on original, attach additional sheets and reference the questions being answered. Please do not use abbreviations when completing the application. If an item in the application does not apply to you, write N/A in the box provided. **Current copies of the following documents must be submitted with this application.**

- State Medical License(s)
- DEA Certificate
- Board Certification (if applicable)
- Face Sheet of Professional Liability Policy or Certification
- Curriculum Vitae
- ECFMG (if applicable)

II. IDENTIFYING INFORMATION

Last Name:	First:	Middle:
Is there any other name under which you have been known (AKA/Maiden Name)? Name(s):		
Home Mailing Address:	City:	
	State:	ZIP:
Home Telephone Number:	E-Mail Address:	
Home Fax Number:	Pager Number:	
Birthday Date: Birth Place (City/State/Country):	Citizenship (If not a United States citizen, please include a copy of Alien Registration Card).	
Social Security #:	Gender [2]: ☐ Male ☐ Female	
Specialty:	Race/Ethnicity [2] (voluntary):	
Subspecialties:		

III. PRACTICE INFORMATION

Practice Name (if applicable):	Department Name (if Hospital based):
Primary Office Street Address:	Primary Office Mailing Address if different from Street Address:
City: State: County: Zip:	City: State: County: Zip:
Telephone Number:	FAX Number:
Office Manager/Administrator:	Telephone Number:
	Fax Number:
Name Affiliated with Tax ID Number:	Federal Tax ID Number:

[1] As used in the information Release/Acknowledgements Section of this application, the term "this Managed Care Entity" shall refer to the entity to which the application is submitted as identified above.

[2] This information will be used for consumer information purposes only.

Secondary Office Street Address:	City: State: ZIP:
Office Manager/Administrator:	Telephone Number: FAX Number:
Name Affiliated with Tax ID Number:	Federal Tax ID Number:
Tertiary Office Street Address:	City: State: ZIP:
Office Manager/Administrator:	Telephone Number: ( ) FAX Number: ( )
Name Affiliated with Tax ID Number:	Federal Tax ID Number:
Handicap Access: ☐ Yes ☐ No	24 Hour Coverage: ☐ Yes ☐ No
Will you accept new patients? ☐ Yes ☐ No	Back office Telephone Number: ( )

Please identify other networks in which you participate:

Please identify other networks from which you have been denied admission or de-selected:

Name of Network	**Address**	**Reason for Denial or Deselection**

Do you have ownership in any health or medical related organization, e.g., laboratory, home health care agency, radiology facility, lithotrips, mobile testing, MRI, etc? ☐ Yes ☐ No

If Yes, please list:

Medical Group(s) / IPA(s) Affiliation:

Do you intend to serve as a primary care provider? ☐ Yes ☐ No
Do you intend to serve as a specialist? ☐ Yes ☐ No
If Yes, please list specialty(s):

Please check all that apply:
☐ Solo Practice ☐ Single Specialty
☐ Group Practice ☐ Multi Specialty

Do you employ any allied health professionals (e.g. nurse practitioners, physician assistants, psychologists, etc.)? ☐ Yes ☐ No
If so, please list:

Name:	Type of Provider:	License Number:

Do you personally employ any physicians? (Do Not include physicians that are employed by the medical group) ☐ Yes ☐ No

Name:	Mississippi Medical License Number:

Please list any clinical services you perform that are not typically associated with your specialty:

Please list any clinical services you **do not** perform that are typically associated with your specialty:

Is your practice limited to certain ages? ☐ Yes ☐ NO If Yes, specify limitations:

Do you participate in EDI (electronic date interchange)? ☐ Yes ☐ No
If so, which Network**?**

Do you use a practice management system/software: ☐ Yes ☐ No
If so, which one?

What type of anesthesia do you provide in your group/office?
☐ Local ☐ Regional ☐ Conscious Sedation ☐ General ☐ None ☐ Other (please specify):

Has your office received any of the following accreditation's, certifications, or licensures?

☐ American Association for Accreditation of Ambulatory Surgery Facilities (AAASF) ☐ Medicare Certification
☐ Mississippi Department of Health Licensure ☐ Other:

IV. BILLING INFORMATION

Billing Company

Street Address:

City:

State**:**

ZIP:

Contact:

Telephone Number:

Name Affiliated with Tax ID Number:

Federal Tax ID Number:

V. OFFICE HOURS – Please indicate the hours your office is open:

Monday 24 HOUR COVERAGE	Tuesday 24 HOUR COVERAGE	Wednesday 24 HOUR COVERAGE	Thursday 24 HOUR COVERAGE	Friday 24 HOUR COVERAGE	Saturday 24 HOUR COVERAGE	Sunday 24 HOUR COVERAGE	Holidays 24 HOUR COVERAGE

VI. COVERAGE OF PRACTICE (List your answering service and covering physicians by name. Attach additional sheets if necessary. Reference this section number and title)

Answering Service Company:

Telephone Number: ( )

Fax Number: ( )

Mailing Address:

City:

State:

ZIP:

Covering Physician's Name:

Telephone Number: ( )

Covering Physician's Name:

Telephone Number: ( )

Covering Physician's Name:

Telephone Number: ( )

Covering Physician's Name:

Telephone Number: ( )

If you do not have hospital privileges, please provide written plan for continuity of care:

VII. FOREIGN LANGUAGES SPOKEN

Fluently by Physician:	Fluently by Staff:

VIII. LABORATORY SERVICES

If you provide direct laboratory services, please indicate the TIN utilized and provide Clinical Laboratory Information Act (CLIA) information. Attach a copy of your CLIA certificate or waiver if you have one.

Tax ID #:	Billing Name:	Type of Service Provided:

Do you have a CLIA Certificate? ☐ Yes ☐ No	Do you have a CLIA waiver? ☐ Yes ☐ No
Certificate Number:	Certificate Expiration Date:

IX. MEDICAL/PROFESSIONAL EDUCATION (Attach additional sheets if necessary. Reference this section number and title.)

Medical School:	Degree Received:	Date of Graduation (mm/yy)
Mailing Address:	City:	
	State & Country:	ZIP:
Medical/Professional School:	Degree Received:	Date of Graduation (mm/yy)
Mailing Address:	City:	
	State & Country	ZIP:

X. INTERNSHIP/PGYI (Attach additional sheets if necessary, Reference this section number and title.)

Institution:	Program Director:	
Mailing Address:	City:	
	State & Country:	ZIP:
Type of Internship:		
Specialty:	From: (mm/yy)	To: (mm/yy)

XI. RESIDENCES/FELLOWSHIPS (Attach additional sheets if necessary. Reference this section number and title.)

Include residencies, fellowships, preceptorships, teaching appointments (indicate whether clinical or academic). And postgraduate education in chronological order, giving name, address, city, state, country, zip code and dates. Include all programs you attended, whether or not completed.

Institution:	Program Director:	
Mailing Address:	City:	
	State & Country:	ZIP:
Type of Training (e.g. residency, etc)	Specialty:	From: (mm/yy) / To: (mm/yy)

Did you successfully complete the program?
☐Yes ☐No (If "No", please explain on separate sheet.)

Institution:		Program Director:	
Mailing Address:		City:	
		State & Country:	ZIP:
Type of Training (e.g. residency, etc)	Specialty:	From: (mm/yy)	To: (mm/yy)

Did you successfully complete the program?
☐Yes ☐No (If "No", please explain on separate sheet.)

Institution:		Program Director:	
Mailing Address:		City:	
		State:	ZIP:
Type of Training (e.g. residency, etc)	Specialty:	From: (mm/yy)	To: (mm/yy)

Did you successfully complete the program?
☐Yes ☐No (If "No", please explain on separate sheet.)

XII. BOARD CERTIFICATION (Attach copies of documents.)

Include certifications by board(s) which are duly organized and recognized by:
- a member board of the American Board of Medical Specialties
- a member board of the American Osteopathic Association
- a board or association with an Accreditation Council for Graduate Medical Education of American Osteopathic Association approved post graduate training that provides complete training in that specialty or subspecialty.

Name of Issuing Board:	**Specialty:**	**Certification Number**:	**Date Certified/ Rectified:**	**Expiration Date (if any):**

Have you applied for board certification other than those indicated above?
☐ Yes ☐No

If so, list board(s) and date(s):

If not certified, describe your intent for certification, if any, and date of admissibility for certification on separate sheet.

Have you taken or failed a board exam? ☐ Yes ☐ No If Yes, Provide details.

XIII. OTHER CERTIFICATIONS (e.g. Fluoroscopy, Radiography, etc.) (Attach additional sheets if necessary. Reference this section number and title.)

Type:	Number:	Expiration Date:
Type:	Number:	Expiration Date:

XIV. MEDICAL LICENSURE/REGISTRATIONS (Attach copies of documents)

Mississippi State Medical License Number:	Issue Date:	Expiration Date:	Active: ☐ Yes ☐ No
Drug Enforcement Administration (DEA) Registration Number: Unlimited? ☐ Yes ☐ No If "No", please explain on separate sheet		Expiration Date:	
Controlled Dangerous Substances Certificate (CDS) (if applicable):		Expiration Date:	

ECFMG Number (applicable to foreign medical graduates):	Date Issued:	Valid Through:
Visa Number:	Date Issued:	Valid Through:

Medicare UPIN/National Physician Identifier (NPI):	Mississippi Medicare Number:	Mississippi Medicaid Number:

XV. ALL OTHER STATE MEDICAL LICENSES – List all Medical licenses now or Previously Held. (Attach additional sheets if necessary. Reference this section number and title.)

State	License Number:	Expiration Date:	Active:
			☐ Yes ☐ No
State:	License Number:	Expiration Date:	Active:
			☐ Yes ☐ No
State:	License Number:	Expiration Date:	Active:
			☐ Yes ☐ No

XVI. PROFESSIONAL ORGANIZATIONS

Please list county, state or national medical societies, or other professional organizations or societies of which you are a member or applicant.

ORGANIZATION NAME	Applicant	Member
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

Are you an Officer or Director of any of the professional organizations listed above?
If Yes, please list: ☐ Yes ☐ No

XVII. PROFESSIONAL LIABILITY (Attach copy of professional liability policy or certification face sheet.)

Current Insurance Carrier:	Policy Number:	Original effective date:
Mailing Address:	City:	
	State & Country:	ZIP:
Telephone Number: ( )	Fax Number: ( )	
Per Claim Amount: $	Aggregate Amount: $	Expiration Date:

Please explain any surcharges to your professional liability coverage on a separate sheet. Reference this section number and title.

If you have had professional liability carriers in the last five years other than the one listed above, please list them below.

Name of Carrier:	Policy # :	From: (mm/yy)	To: (mm/yy)
Mailing Address:		City:	
		State and Country::	ZIP:
Name of Carrier:	Policy # :	From: (mm/yy)	To: (mm/yy)
Mailing Address:		City:	
		State and Country:	ZIP:

Name of Carrier:	Policy # :	From: (mm/yy)	To: (mm/yy)
Mailing Address:		City:	
		State & Country:	ZIP:
Name of Carrier:	Policy # :	From: (mm/yy)	To: (mm/yy)
Mailing Address:		City:	
		State & Country:	ZIP:

XVII. CURRENT HOSPITAL AND OTHER INSTITUTIONAL AFFILIATIONS

Please list in (A) in reverse chronological order, with the most current affiliation(s) first, all institutions with which you are currently affiliated. List previous affiliations during the past ten years in (B). Include hospitals, surgery centers, institutions, corporations, military assignments, or government agencies.

A. CURRENT AFFILIATIONS **(Attach additional sheets if necessary. Reference this section number and title.)**

Name and Mailing Address of Primary Admitting Hospital:	City:	
	State:	ZIP:
Department/Status (Active, provisional, courtesy, etc.):	Appointment Date:	
Name and Mailing Address of Other Hospital/Institution:	City:	
	State:	ZIP:
Department/Status (Active, provisional, courtesy, etc.):	Appointment Date:	
Name and Mailing Address of Other Hospital/Institution:	City:	
	State:	ZIP:
Department/Status (Active, provisional, courtesy, etc)	Appointment Date:	
If you do not have hospital privileges, please explain.		

B. PREVIOUS AFFILIATIONS **(Limit to last ten years. Attach additional sheets if necessary. Reference this section number and title.)**

Name and Mailing Address of Other Hospital/Institution:	City:	
	State:	ZIP:
From: (mm/yy) To: (mm/yy)	Reason for Leaving:	
Name and Mailing Address of Other Hospital/Institution:	City:	
	State:	ZIP:
From: (mm/yy) To: (mm/yy)	Reason for Leaving:	
Name and Mailing Address of other Hospital/institution:	City:	
	State:	ZIP:
From: (mm/yy) To: (mm/yy)	Reason for Leaving:	

Name and Mailing Address of Other Hospital/Institution:	City:	
	State:	ZIP:
From: (mm/yy)	To: (mm/yy)	Reason for Leaving:

XIX. PEER REFERENCES

List three professional references, preferably from your specialty area. Do not list relatives, current partners or associates in practice. If possible, include at least one member from the Medical Staff of each facility at which you have privileges. Do not include program directors previously listed under post graduate training and education in Section X.

NOTE: References must be from individuals who are directly familiar with your work, either via direct clinical observation or through a close working relationship.

Name of Reference:	Specialty:	Telephone Number:
Mailing Address:	City:	
	State:	ZIP:

Name of Reference:	Specialty:	Telephone Number:
Mailing Address:	City:	
	State:	ZIP:

Name of Reference:	Specialty:	Telephone Number:
Mailing Address:	City:	
	State:	ZIP:

XX. WORK HISTORY (Attach additional sheets if necessary. Reference this section number and title.)

Chronologically list all work history for at least the past five years (use extra sheets if necessary). This information must be complete. A curriculum vitae is sufficient provided it is current and contains all information requested below. Please explain any gaps in professional work history on a separate page.

Current Practice:	Contact Name:	Telephone Number:
		Fax Number:
Mailing Address:	City:	
	State:	ZIP:
From: (mm/yy)	To: (mm/yy)	

Name of Practice/Employer:	Contact Name:	Telephone Number:
		Fax Number: ( )
Mailing Address:	City:	
	State:	ZIP:
From: (mm/yy)	To: (mm/yy)	

Name of Practice/Employer:	Contact Name:	Telephone Number: ( )
		Fax Number: ( )
Mailing Address:		City:
		State: / ZIP:
From: (mm/yy)		To: (mm/yy)

Section B.

Professional Liability Action Explanation

Please complete this section for each pending, settled, or otherwise concluded professional liability lawsuit or arbitration filed and served against you, in which you were named a party in the past five (5) years, whether the lawsuit or arbitration is pending, settled or otherwise concluded, and whether or not any payment was made on your behalf by any insurer, company, hospital, or other entity. All questions must be answered completely in order to avoid delay in expediting your application. If there is more than one professional liability lawsuit or arbitration action, please photocopy this Section B prior to completing, and complete a separate form for each lawsuit.

I. CASE INFORMATION

City, County and State where lawsuit filed:	Court case number, if known:		
Date of alleged incident serving as basis for the lawsuit/arbitration:	Date Suit Filed:	Sex of patient:	Age of patient:

Location of Incident:

☐ Hospital ☐ My office ☐ Other doctor's office ☐ Surgery Center

☐ Other, (please specify) _____

Your relationship to Patient (Attending Physician, Surgeon, Assistant, Consulting, etc.):

Allegation:

Is/was there any insurance company or other liability protection company or organization providing coverage/defense of the lawsuit or arbitration action? ☐ Yes ☐ No

If Yes, please provide company name, contact person, phone number, location and claim identification number of insurance company or other liability protection company or organization.

If you would like us to contact your attorney regarding any of the above, please provide attorney(s) name(s) and phone number(s). Please fax this document to your attorney to serve as your authorization:

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

II. WHAT IS THE STATUS OF THE LAWSUIT/ARBITRATION DESCRIBED ABOVE? (CIRCLE ONE)

☐ Lawsuit/arbitration still ongoing, unresolved.

☐ Judgement rendered and payment was made on my behalf. Amount paid on my behalf: _____

☐ Judgement rendered and I was found not liable.

☐ Lawsuit/arbitration settled and payment made on my behalf. Amount paid on my behalf: _____

☐ Lawsuit/arbitration settled, no judgement rendered, no payment made on my behalf.

Summarize the circumstances giving rise to the action. If the action involves patient care, provide a narrative, with adequate clinical detail, including your description of your care and treatment of the patient. If more space is needed, attach additional sheet(s). Include: (1) condition and diagnosis at time of incident. (2) dates and description of treatment rendered, and (3) condition of patient subsequent to treatment. **Please print.**

SUMMARY

SECTION C.
Certification

I certify that the information in Section A and B of this application and any attached documents (including my curriculum-vitae if attached) is true, current, correct and complete to the best of my knowledge and belief and is furnished in good faith. I understand that intentionally withholding or omitting material information or intentionally submitting material false or misleading information may result in denial of my application or termination of my privileges, employment or physician participation agreement. I agree that the Managed Care Entity to which this application is submitted, its representatives, and any individuals or entities providing information to this Managed Care Entity in good faith shall not be liable, to the fullest extent provided by law, for any act or occasion related to the evaluation or verification contained in this Mississippi Participating Physician Application. In order for participating Managed Care Entities or Healthcare Organizations to evaluate my application for participation in and/or my continued participation in those organizations, I hereby give permission to release to this Managed Care Entity information about my medical malpractice insurance coverage and malpractice claims history. This authorization is expressly contingent upon my understanding that the information provided will be maintained in a confidential manner and will be shared only in the context of legitimate credentialing and peer review activities. This authorization is valid unless and until it is revoked by me in writing. I authorize the attorneys listed in Section B, Page 9, to discuss any information regarding the subject case with this Managed Care Entity.

Print Name Here: _____

Physician Signature: _____ Date: _____
(Stamped Signature Is not Acceptable)

Section D.

Attestation Questions

Please answer the following questions "Yes" or "No". If your answer to any question is "Yes" please provide full details on separate sheet.

1. Has your license to practice medicine in any jurisdiction, your Drug Enforcement Administration (DEA) registration or any applicable narcotic registration in any jurisdiction ever been denied, limited, restricted, suspended, revoked, not renewed, or subject to probationary conditions, or have you voluntarily or involuntarily relinquished any such license or registration or voluntarily or involuntarily accepted any such actions or conditions, or have you been fined or received a letter of reprimand or is such action pending**?**

Yes ☐ No ☐

2. Have you ever been charged, suspended, fined, disciplined, or otherwise sanctioned, subjected to probationary conditions, restricted or excluded, or have you voluntarily or involuntarily relinquished eligibility to provide services or accepted conditions on your eligibility to provide services, for reasons relating to possible incompetence or improper professional conduct, or breach of contract or program conditions, by Medicare, Medicaid, or any public program, or is any such action pending**?**

Yes ☐ No ☐

3. Have your clinical privileges, membership, contractual participation or employment by any medical organization (e.g. hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with public programs), medical society, professional association, medical school faculty position or other health delivery entity or system), ever been denied, suspended, restricted, reduced, subject to probationary conditions, revoked or not renewed for possible incompetence, improper professional conduct or breach of contract or is any such action pending?

Yes ☐ No ☐

4. Have you ever surrendered, allowed to expire, voluntarily or involuntarily withdrawn a request for membership or clinical privileges, terminated contractual participation or employment, or resigned from any medical organization (e.g., hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), medical society, professional association, medical school faculty position or other health delivery entity or system) while under investigation for possible incompetence or improper professional conduct, or breach of contract, or in return for such an investigation not being conducted, or is any such action pending?

Yes ☐ No ☐

5. Have you ever surrendered, voluntarily withdrawn, or been requested or compelled to relinquish your status as a student in good standing in any internship, residency, fellowship, preceptorship, or other clinical education program?

Yes ☐ No ☐

6. Has your membership or fellowship in any local, county, state, regional, national, or international professional organization ever been revoked, denied, reduced, limited, subjected to probationary conditions, or not renewed, or is any such action pending?

Yes ☐ No ☐

7. Have you been denied certification/recertification by a specialty board, or has your admissibility, certification or recertification status changed (other than changing from admissible to certified)?

Yes ☐ No ☐

8. Have you ever been convicted of any crime (other than a minor traffic violation)?

Yes ☐ No ☐

9. Are you currently engaged in the illegal use of drugs? ("Illegal use of drugs" means the use of controlled substances, obtained illegally, as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the direction of a licensed health care practitioner. "Currently" does not mean on the day of or even the weeks preceding the completion of this application, rather, it means recently enough so that the illegal use may have an impact on one's ability to practice.)

Yes ☐ No ☐

10. Have any judgements or claims been entered against you, or settlements been agreed to by you within the last five (5) years, in professional liability cases, or are there any filed and served professional liability lawsuits/arbitration's against you pending?

Yes ☐ No ☐

11. To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank?

Yes ☐ No ☐

12. Has your professional liability insurance ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged), or have you ever been denied professional liability insurance, or has any professional liability carrier provided you with written Notice of any intent to deny, cancel, not renew, or limit your professional liability insurance or its coverage of any procedures?

Yes ☐ No ☐

13. Are you capable of performing all the services required by your agreement with, or the professional staff bylaws of the Managed Care Entity to which you are applying, with or without reasonable accommodation, according to accepted standards of professional performance and without posing a direct threat to the safety of patients, yourself, or others? (**A "YES" ANSWER TO THIS QUESTION DOES NOT REQUIRE AN EXPLANATION.)**

Yes ☐ No ☐

14. Have you ever been reprimanded, censured, excluded, suspended, or disqualified by CLIA, or any other health plan for which you provided services? Yes ☐ No ☐

I hereby affirm that the information submitted in this Section D Attestation Questions, and any addenda thereto is true, current, correct and complete to the best of my knowledge and belief and is furnished in good faith. I understand that intentionally withholding or omitting material information or intentionally submitting material false or misleading information may result in denial of my application or termination of my privileges, employment or physician participation agreement.

Print Name Here: _____

Physician Signature: _____ Date: _____

(Stamped Signature Is Not Acceptable)

Section E.
Information Release/Acknowledgements

I hereby consent to the disclosure, inspection and copying of information and documents relating to my credentials, qualifications and performance ("credentialing information") by and between "this Managed Care Entity" and other Healthcare Organizations (e.g. hospital medical staffs, medical groups, independent practice associations (IPAs), health plans, health maintenance organizations (HMOs), preferred provider organizations (PPOs), other health delivery systems or entities, medical societies, professional associations, medical school faculty positions, training programs, professional liability insurance companies (with respect to certification of coverage and claims history), licensing authorities, and businesses and individuals acting as their agents (collectively. "Healthcare Organizations"), for the purpose of evaluating this applications and any recredentialing application regarding my professional training, experience, character, conduct and judgement, ethics, and ability to work with others. In this regard, the utmost care shall be taken to safeguard the privacy of patients and the confidentiality of patient records, and to protect credentialing information from being further disclosed.

I am informed and acknowledge that federal and state (3) laws provide immunity protections to certain individuals and entities for their acts and/or communications in connection with evaluating the qualifications for participation in this Managed Care Entity to the extent that those acts and/or communications are protected by state or federal law.

I understand that I shall be afforded such fair procedures with respect to my participation in this Managed Care Entity as may be required by state and federal law and regulation.

I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubt about such qualifications.

During such time as this application is being processed, I agree to update the application should there by any change in the information provided.

In addition to any notice required by any contract with a Managed Care Entity or Healthcare Organization. I agree to notify this Managed Care Entity immediately in writing of the occurrence of any of the following: (i) the unstayed suspension, revocation or nonrenewal of my license to practice medicine; (ii) any suspensions, revocation or nonrenewal of my DEA or other controlled substances registration; or (iii) any cancellations or Nonrenewal of my professional liability insurance coverage.

I further agree to notify this Managed Care Entity in writing, promptly and NO later than fourteen (14) calendar days from the occurrence of any of the following: (i) receipt of written notice of any adverse action against me by the Mississippi Board of Medical Licensure taken or pending, including by not limited to, any accusations filed, temporary restraining order, or imposition of any interim suspension, probation or limitations affecting my license to practice medicine; or (ii) any adverse action by me by any Managed Care Entity or Healthcare Organization which has resulted in the filing of a report with the National Practitioner Data Bank; or (iii) the denial, revocation, suspension, reduction, limitation, nonrenewal or voluntary relinquishment by resignation of my medical staff membership or clinical privileges at any Managed Care Entity or Healthcare Organization; or (iv) any material reduction in my professional liability insurance coverage; or (v) my receipt of written notice of any legal action against me, including , without limitation, any filed and served malpractice suit or arbitration action; or (vi) my conviction of any crime (excluding minor traffic violations), or (vii) my receipt of written notice of any adverse action against me under the Medicare or Medicaid programs, including, but not limited to, fraud and abuse proceedings or convictions.

I understand and acknowledge that the National Practitioner Data Bank may be queried on my behalf to secure information about my history. A photocopy of facsimile of this document shall be as effective as the original, however, original signatures and current dates are required on pages 10, 11, and 12 of this application.

Print Name Here:_____

Physician Signature: _____Date_____
(Stamped Signature Is Not Acceptable)

Individual Managed Care Entities may request additional information or attach supplements to this form. Such additions or supplements are not part of the Mississippi Participating Physician Application and have not been endorsed by the organizations below. Questions about supplements shall be addressed to the Managed Care Entity requesting them.

This Application is endorsed by:
- ***Mississippi Association of Health Plans***
- ***Mississippi State Medical Association***
- ***Mississippi Hospital Association***

[3] The intent of this release is to apply at a minimum, protections comparable to those in Mississippi to any action, regardless of where such action is brought.

Mississippi Physicians Care Network

Disclosure of Ownership and Control Interest Statement

The federal regulations set forth in 42 CFR 455.104, 455.105 and 455.106 require providers who are entering into or renewing a provider agreement to disclose to the U.S. Department of Health and Human Services, the state Medicaid agency, and to managed care organizations that contract with the state Medicaid agency: 1) the identity of all owners with a control interest of *5%* or greater, 2) certain business transactions as described in 42 CFR 455.105 and 3) the identity of any excluded individual or entity with an ownership or control interest in the provider, the provider group, or disclosing entity or who is an agent or managing employee of the provider group or entity. If there are any changes to the information disclosed on this form, an updated form should be completed and submitted to (*Health Plan/Entity Name*) within 30 days of the change. Please attach a separate sheet if necessary to provide complete information. Failure to submit the accurate, complete information requested in a timely manner may lead to the termination or denial of enrollment into the network as specified in 42 CFR 455.416.

Practice Information

Check one that most closely describes you: ☐ Individual ☐ Group Practice ☐ Disclosing Entity
Name of Individual, Group Practice, or Disclosing Entity
Entity: DBA Name:
Address:
Federal Tax Identification Number:

Section I

For individuals, list the name, title, address, date of birth (DOB) and Social Security Number (SSN) for each individual having an ownership or control interest in this provider entity of 5% or greater.

For entities, list the name, Tax Identification Number (TIN), business address of each organization, corporation, or entity having an ownership or control interest of 5% or greater. Please attach a separate sheet if necessary.(42 CFR 455.104)

Name of individual or entity	DOB	Address	SSN (if listing an individual) TIN (if listing an entity)

Section II

Are any of the individuals listed above related to each other? ☐ Yes ☐ No

If yes, list the individuals named above who are related to each other (spouse, sibling, parent, child). (42 CFR 455.104)

Names	Type of relation

Section III

Are there any subcontractors that the Disclosing Entity has direct or indirect ownership of 5% or more? ☐Yes ☐ No

If yes, list the name and address of each person with an ownership or controlling interest in any subcontractor used in which the disclosing entity has direct or indirect ownership of 5% or more. (42 CFR 455.104)

Name of individual or entity	DOB	Address	SSN (if listing an individual) TIN (if listing an entity)

Section IV

Has any person who has an ownership or control interest in the provider, or is an agent or managing employee of the provider ever been convicted of a crime related to that person's involvement in any program under Medicaid, Medicare, or Title XX program? ☐ Yes ☐ No (verify through OIG Website)

If yes, please list those persons below. (42 CFR 455.106)

Name/Title	DOB	Address	SSN

Section V

Business Transactions: Has the disclosing entity had any financial transaction with any subcontractors totaling more that $25,000 or any significant business transactions with any subcontractors? ☐ Yes ☐ No

If yes, list the ownership of any subcontractor with whom this provider has had business transactions totaling more than $25,000 during the previous twelve month period; and any significant business transactions between this provider and any wholly owned supplier, or between the provider and any subcontractor, during the past 5-year period. (42 CFR 455.105).
Attach a separate sheet if necessary.

Name Supplier/Subcontractor	Address	Transaction Amount

Section VI

Have you identified your status (under Practice Information 1) as a Disclosing Entity? ☐ Yes ☐ No

If yes, for Disclosing Entities, list each member of the Board of Directors or Governing Board, including the name, date of birth (DOB), Address, Social Security Number (SSN), and percent of interest

Name/Title	DOB	Address	SSN	% Interest

I certify that the information provided herein, is true and accurate. Additions or revisions to the information above will be submitted immediately upon revision. Additionally, I understand that misleading, inaccurate, or incomplete data may result in a denial of participation.

Signature **Title (or indicate if authorized Agent)**

Name (please print) **Date**

Disclosure of Ownership and Control Interest Statement Form Instructions

Practice/Entity Information Section

Type of Entity Check Box – Check the box that most closely describes the type of entity you are contracting as. See the Definitions Page to assist in determine if the practice/entity is an Individual, Group Practice or Disclosing Entity.

Name of Individual, Group Practice or Disclosing Entity – Provide the name of the entity you are contracting as. If you are an individual practitioner who is participating through a Group Practice, enter your individual name here.

DBA name (if applicable) – If you are completing the form as a Disclosing Entity or Group Practice, enter any DBA name that your entity may utilize here. If you are an individual practitioner who is participating through a Group Practice, enter the Group Practice name here.

Address – Provide the main physical address of practice/Entity you are contracting as.

Federal Tax ID Number – Enter the Federal Tax ID Number for your Disclosing Entity or Group Practice. If you are an individual who is also participating through a Group Practice, enter your individual Federal Tax ID number here.

Provider CAQH # - If completing this form as an Individual, enter the CAQH number here if applicable.

Section I – Provide the all information requested for any individual or entity with an ownership or controlling interest in the Practice/Entity completing the form. See the "Determination of ownership or control interest guidelines" on page 3. Attach a separate sheet as necessary to provide complete information. Write "None" if you are an individual practitioner or if this does not apply.

Section II – Indicate whether or not any individuals listed in Section I are related to each other by checking either the "Yes" or "No" box as applicable. If "Yes" is checked, list any owners that are related to each other and the type of relationship in the rows provided, attach a separate sheet if necessary to provide all information.

Section III – Indicate whether or not the Disclosing Entity has a 5% or more direct or indirect ownership in a subcontractor by checking either the "Yes" or "No" box as applicable. If "Yes" is checked, provide the information requested for each subcontracted entity of which the Disclosing Entity has a 5% or more direct or indirect ownership.

Section IV – Indicate whether or not there are any individuals who have an ownership or control interest in the Disclosing Entity, or is an agent or managing employee of the Disclosing Entity who have been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the Social Security Title XX services program since the inception of those programs by checking either the "Yes" or "No" box as applicable. If "Yes" is checked, provide the information requested for each individual.

Section V – Indicate by checking either the Yes or No box whether or not the practice/entity has had any financial transaction with a subcontractor totaling more than $25,000 in the 12 months prior to the completion date of this form or any significant business transaction (see definitions) between the practice/entity and a wholly owned supplier or between the practice/entity and any subcontractor in the 5 years prior to the completion date of this form. If Yes, provider the Name, address

Section VI – If the practice/entity is completing this form as a Disclosing Entity, as indicated in the Practice/Entity Information section, check yes and list each member of the Board of Directors or Governing Board including the name, date of birth, address, social security number (SSN) and percent of interest (if known at the time of completion). If your practice/entity is not a Disclosing Entity,

Signature/Title/Date – Provide the printed name, signature and title of the individual completing the form either for themselves if an individual practitioner on behalf of a disclosing entity. In the date field, enter the date the form was completed.

Disclosure of Ownership and Control Interest Statement Form Instructions

Definitions

Agent means any person who has been delegated the authority to obligate or act on behalf of a provider.

Disclosing entity means a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent. This includes:

(a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XVIII);
(b) Any Medicare intermediary or carrier; and
(c) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Act.

Group of practitioners means two or more health care practitioners who practice their profession at a common location (whether or not they share common facilities, common supporting staff, or common equipment).

Indirect ownership interest means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

Managing employee means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency.

Ownership interest means the possession of equity in the capital, the stock, or the profits of the disclosing entity.

Person with an ownership or control interest means a person or corporation that—

(a) Has an ownership interest totaling 5 percent or more in a disclosing entity;
(b) Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;
(c) Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;
(d) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;
(e) Is an officer or director of a disclosing entity that is organized as a corporation; or
(f) Is a partner in a disclosing entity that is organized as a partnership.

Significant business transaction means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $25,000 and 5 percent of a provider's total operating expenses.

Subcontractor means—

(a) An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or
(b) An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

Supplier means an individual, agency, or organization from which a provider purchases goods and services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of hospital beds, or a pharmaceutical firm).

Wholly owned supplier means a supplier whose total ownership interest is held by a provider or by a person, persons, or other entity with an ownership or control interest in a provider.

Disclosure of Ownership and Control Interest Statement Form Instructions

Determination of ownership or control percentages

Indirect ownership interest. The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example, if A owns 10 percent of the stock in a corporation which owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership interest in the disclosing entity and must be reported. Conversely, if B owns 80 percent of the stock of a corporation which owns 5 percent of the stock of the disclosing entity, B's interest equates to a 4 percent indirect ownership interest in the disclosing entity and need not be reported.

Person with an ownership or control interest. In order to determine percentage of ownership, mortgage, deed of trust, note, or other obligation, the percentage of interest owned in the obligation is multiplied by the percentage of the disclosing entity's assets used to secure the obligation. For example, if A owns 10 percent of a note secured by 60 percent of the provider's assets, A's interest in the provider's assets equates to 6 percent and must be reported. Conversely, if B owns 40 percent of a note secured by 10 percent of the provider's assets, B's interest in the provider's assets equates to 4 percent and need not be reported.

Disclosure of Ownership and Control Interest Statement Form

Provider Type Scenarios

Sole Practitioner – Sole Practitioners would identify themselves as Individuals, indicate “None” in Section I, indicate “Yes” or “No” in the remaining check boxes as appropriate then sign and date the form.

Group of Practitioners – the Group Practice being contracted with the Health Plan would fill out one Disclosure and Control Interest form for the Group Practice. The individual practitioners participating in the Group Practice, either as employees or co-owners, would each fill out a Disclosure and Control interest form for themselves as an Individual and list the Group Practice name in the “DBA Name” section, use the Group Practice address and use their own individual Federal Tax ID number.

Hospital or Hospital System – The Hospital would fill out one Disclosure and Control Interest form as a Disclosing Entity. We do not need a separate Disclosure and Control interest form for each practitioner who contracts and bills through the Hospital entity.

Independent Clinical Lab – The entity would fill out one Disclosure and Control Interest form as a Disclosing Entity. If the Independent Clinical Lab employs a group of practitioners that will be enrolled with the Health Plan, each practitioner would fill out a Disclosure and Control Interest form for themselves as an Individual and list the Independent Clinic Lab name in the “DBA Name” section, use the Independent Clinic Lab address and use their own individual Federal Tax ID number.

MISSISSIPPI PHYSICIANS CARE NETWORK
PHYSICIAN SERVICE AGREEMENT

This PHYSICIAN SERVICE AGREEMENT ("Agreement") is made and entered into this__day of_____,_____by and between Mississippi Physicians Care Network, Inc. ("MPCN"), a Mississippi corporation, located at 601 Crescent Boulevard, Suite 103, Ridgeland, MS 39157, and _____,("Participating Physician"), having his or her principal place of business at_____.

WHEREAS, MPCN's primary objective is to arrange for the provision of high quality, cost effective health care services to Health Plans and their Beneficiaries; and

WHEREAS, MPCN intends to enter into agreements with Participating Physicians which authorize MPCN to contract with self-insured employers, insurance companies, health and welfare trust funds and other entities ("Payors") which maintain or sponsor health plans; and,

WHEREAS, Participating Physician is licensed to practice medicine, and

WHEREAS, MPCN and Participating Physician desire to enter into an agreement whereby Participating Physician agrees to provide Covered Services to Beneficiaries of Health Plans which contract with MPCN and Participating Physician agrees to comply with certain MPCN administrative requirements and quality assurance/utilization review procedures, in providing such covered services, and

NOW, THEREFORE, in consideration of the mutual covenants and promises contained herein, the parties agree as follows:

ARTICLE I
Definitions

1.1 "Beneficiaries" means subscribers, enrollees or members and dependents of the subscriber, enrollee or member to a health plan who are eligible to receive covered services under a Health Plan which utilizes Participating Physicians.

1.2 "Complete Claim" means a written or electronic request for payment submitted on the most current editions of the CMS-approved Form 1500 and/or CMS Form UB92, or their successor forms, as identified by the Department of Insurance, Regulation 48, "Health Insurance Standardized Claim Forms" and which is accurate and complete and as to which request for payment there is no material issue regarding Payor's obligation to pay under the terms of a Health Plan.

1.3 "Covered Services" means the medical and other ancillary services and related benefits to which Covered Individuals are entitled under the Evidence of Coverage and for which the Health Plan provides funding.

1.4 "Emergency" means the sudden and unexpected onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected as determined by a prudent layperson to

jeopardize the Beneficiary's life, cause serious injury or impairment of bodily functions, or cause serious injury or permanent dysfunction of any bodily organ or part.

1.5 "Evidence of Coverage" means a document which explains services and benefits covered by a Health Plan and defines the rights and responsibilities of the Beneficiary.

1.6 "Health Plan" means a group policy issued through a licensed insurance company or a benefit agreement offered by a self-funded organization pursuant to which a Beneficiary has a financial incentive to use Participating Providers of MPCN.

1.7 "Medically Necessary" means services or supplies determined in good faith and in accordance with the utilization review functions of the companies to be necessary for the diagnosis or treatment of a medical condition, provided in accordance with generally accepted professional standards of medical care, requested and authorized in accordance with the Evidence of Coverage requirements, and not provided primarily for the convenience of the Beneficiary or the Participating Physician.

1.8 "Participating Hospital" means a hospital which has entered into an agreement with MPCN to provide hospital services to Beneficiaries in accordance with the terms and conditions of the Evidence of coverage.

1.9 "Participating Physician" means a physician with an unencumbered license to practice medicine or osteopathy who has entered into an agreement with MPCN to provide Covered Services to Beneficiaries.

1.10 "Participating Provider" means a hospital, other health care facility, pharmacy, or other individual health care professional which has entered into an agreement with MPCN to provide Covered Services to Beneficiaries of Health Plans.

1.11 "Payors" means any entity which self-insures group health benefits offered to their employees or an insurance company or other entity that has signed an agreement with MPCN for subscriber and eligible dependent coverage under a Health Plan as a participant in MPCN.

1.12 "Physician Service" means those services which a Participating Physician agrees to make available to Beneficiaries of Qualified Health Plans, when such services are covered under the Health Plan, and such services are required by a Beneficiary's medical condition. Participating Physicians agree to provide medical care and surgical care as appropriate to Beneficiaries within the parameters of their practice or specialty and within existing office schedules and physician settings which they customarily provide for all patients.

ARTICLE II
Covered Individual Eligibility

2.1 Eligibility and/or scope of Covered Services offered by Payors in Health Plans and performed by Participating Physicians and Providers, as determined by Payors, should be confirmed according to procedures designated on the Beneficiary's enrollment card.

ARTICLE III
Contracting with Participating Physicians

3.1 MPCN shall establish and maintain a panel of Participating Physicians who will provide Covered Services to Beneficiaries upon the terms and conditions set forth herein. MPCN shall use its best efforts to assure that all major medical specialties are included among the Participating Physicians and that Participating Physicians include physicians who provide primary care services and who are readily accessible to Beneficiaries residing throughout the MPCN service area. The parties recognize that the Participating Physicians may vary from time to time. MPCN will provide Companies with copies of a directory listing the names and addresses of all Participating Physicians and Providers.

3.2 Participating Physician acknowledges and agrees that MPCN may at times, in its sole discretion, cooperate with and assist in the network development of certain corporations with which it is affiliated. As a result, Participating Physician may be listed on the provider panels of affiliated corporations when such will further the efficient provision of health care services to beneficiaries; in such an event, Participating Physician agrees that the terms and conditions of this Physician Service Agreement shall continue in full force and effect. Participating Physician will be notified of any such product and may opt-out of individual products by providing MPCN with written notice.

3.3 Participating Physician agrees to pay the MPCN annual membership fee.

3.4 Participating Physician agrees to be re-credentialed by MPCN every three years, as required by NCQA guidelines.

ARTICLE IV
Referral to Participating Providers

4.1 Participating Physician agrees, whenever reasonably and medically appropriate, to admit to a Participating Hospital and to refer Beneficiaries to other Participating Physicians when referrals are medically necessary.

ARTICLE V
Participating Physician Billing Procedures

5.1 Participating Physician agrees to submit claims on all Covered Services directly to entity designated on Beneficiary's enrollment card within the time specified by the Beneficiary's Health Plan from the date the service or services were rendered to Beneficiary. Claims shall be submitted on a standard HCFA Form 1500 or other paper or electronic format acceptable to Payor and shall include gross charges for all services rendered identified by CPT code.

5.2 Participating Physician agrees to accept as payment in full for Covered Services rendered to a Beneficiary the MPCN allowable or billed charges, whichever is less. Participating

Physician may only bill the Beneficiary for any co-payment, deductible or co-insurance required by the Health Plan.

5.3 Participating Physician may bill a Beneficiary for services that are not Covered Services under the Beneficiary's Health Plan.

5.4 Participating Physician agrees that all payments shall be made subject to medical necessity provisions based on valid medical need and subject to any Payor utilization review and procedure. Participating Physician agrees to hold the Beneficiary, MPCN and Payors harmless for any and all fees associated with reimbursement determinations for Covered Services.

5.5 Participating Physician shall submit, within ninety (90) days of date of service to Payor, his/her claim for Covered Services rendered to Beneficiaries consistent with Article V of this Agreement according to each Payor's contract year. Claims submitted after ninety (90) days from contract year will be denied. Such services shall show gross charges for all Covered Services rendered identified by code as it appears in the current Physician's Current Procedural Terminology (CPT). Claims shall be submitted on standard HCFA 1500 Universal Claims Forms or on other forms or using electronic media acceptable to MPCN.

5.6 This provision shall survive the termination of this Agreement on services rendered while this Agreement was in effect.

ARTICLE VI
Payment to Participating Physicians

6.1 Payors, under an agreement with MPCN, shall cause automatic assignment of benefits and pay directly to the Participating Physician for Covered Services.

6.2 Payors, under an agreement with MPCN, shall remit payment for a complete claim within forty-five (45) days from the date of receipt of a non-electronic complete claim and within twenty-five (25) days from the date of receipt of an electronic complete claim for services rendered by a Participating Physician, unless one of the following has occurred:

1. The claim form is incomplete or incorrect;

2. Billing of services rendered is not consistent with current CPT;

3. Services rendered are subject to Coordination of Benefits (COB) and/or Utilization Review; or

4. Beneficiary's eligibility is under review.

6.3 Participating Physicians will be provided with each approved payment an explanation of the payment for the Participating Physician's services rendered to Beneficiaries. The explanation of payment shall identify any portion of the bill or claim which has been disallowed as non-covered or covered but deemed medically inappropriate or unnecessary, any amounts of applicable co-payments and any amounts paid by others through Coordination of Benefits.

6.4 Participating Physician agrees to cooperate with Payors or their agents in coordinating benefits with other payers. Participating Physicians will make a reasonable effort to determine whether any other payer has primary responsibility for the payment of a claim for Covered Services that was rendered to a Beneficiary. If, after Participating Physician has been paid a claim it is determined that another payer is primarily responsible for all or a portion of the claim, Participating Physician agrees to refund to Payor or its agent the amount paid or to be paid by the primary payer.

6.5 Payors shall pay to Participating Physician the lesser of his/her usual and customary fee or the MPCN fee maximum for the Covered Service rendered for all services that are payable in accordance with the Agreement.

6.6 Payment on all claims shall be subject to medical necessity provisions in the Beneficiary's certificate of coverage and payments for Covered Services rendered to Beneficiaries are to be provided only when the services are based on valid medical needs. The Participating Physician agrees to hold the Beneficiary harmless for fees associated with such Covered Services which have been determined to be medical unnecessary.

6.7 Fee maximums are established for each eligible CPT procedure code submitted. These maximums will be representative of the general experience accumulated for medical services rendered by the network of Participating Providers.

ARTICLE VII
Utilization Review

7.1 Participating Physician agrees to participate in and comply with the requirements of the utilization review, quality improvement, credentialing and re-credentialing, grievance procedures and other utilization management programs established by Payors.

7.2 Utilization review may include pre-admission, concurrent and retrospective review of claims and the medical records of Beneficiaries.

7.3 Participating Physicians shall not charge for copies of medical records required by Payors for utilization review.

7.4 Participating Physician agrees that Payors shall have the authority to reduce or omit payment to the extent that review has identified Covered Services that were not medically necessary or appropriate or were not otherwise Covered Services.

7.5 If the Participating Physician has obtained pre-certification of medical necessity, the Payor shall accept the determination of medical necessity for payment purposes, unless the Participating Physician has information showing no medical necessity and failed to disclose this or failed to present complete and accurate information.

7.6 Pre-certification or any other determination of medical necessity does not guarantee payment, which may be denied by Payors for reasons other than medical necessity.

ARTICLE VIII
Confidentiality

8.1 The Participating Physicians, MPCN and the Payors shall maintain the confidentiality of the records of Beneficiaries and related information to the maximum extent required by applicable federal, state, and local laws.

8.2 MPCN and the Payors agree to maintain the confidentiality of any information provided them under the Utilization Review programs and to use such information only for

appropriate insurance and/or plan review purposes, unless specifically authorized otherwise by a Beneficiary or Participating Physician.

ARTICLE IX
Patient Relationship

9.1 It is understood and agreed to by the parties that each Participating Physician shall maintain an independent physician/patient relationship with each Beneficiary and shall be solely responsible to such Beneficiary for his or her treatment. Nothing herein shall be construed to require any Participating Physician to take any action or refuse to take any action inconsistent with professional judgment.

ARTICLE X
Use of Names, Trademarks and Logos

10.1 The Payors and MPCN may identify in advertising and publications and information distributed to Beneficiaries, the names and addresses of all Participating Physicians and all Participating Providers at which Covered Services are available under a Health Plan.

10.2 The Participating Physician, by executing this Agreement, provides his or her consent for the Payors to use his or her name and address in all such advertising, publications and information distributed to Beneficiaries and Payors agree to cease the distribution of all materials and the use of any advertising which includes the name and address of the Participating Physician upon the termination of this agreement.

10.3 Under an agreement with MPCN, the Payors agree to permit MPCN and the Participating Physicians to identify each employer who agrees to offer a Health Plan to their eligible employees in any advertising and publications.

10.4 The Payors stipulate in that agreement the use of any symbols, trademarks, or protected service marks may not be used in any form by MPCN or the Participating Physicians without the Payors' respective and individual written permission.

10.5 The use of the employer's name or any trademark, symbol or service mark shall automatically cease at the time the Payors cease to offer its employees a Health Plan or when the agreement with MPCN is terminated.

ARTICLE XI
Liability

11.1 MPCN will be liable for any claims, actions, damages, or litigation arising solely from any negligent, fraudulent or dishonest acts of MPCN.

11.2 The Participating Physician will be liable for any claims, actions, damages or litigation arising solely from any negligent, fraudulent or dishonest acts of the Participating Physician.

11.3 The Payors, under an agreement with MPCN acknowledge their liability for payment of all legitimate health care claims from Participating Physicians and Providers for Covered Services rendered to Beneficiaries which are medically necessary in addition to any claims, actions, damages or litigation arising solely from any negligent, fraudulent, or dishonest act of the Payors.

ARTICLE XII
Insurance

12.1 Each Participating Physician, at their sole and individual expense, shall maintain professional liability insurance with limits of no less than one million dollars ($1,000,000.00) per occurrence and three million dollars ($3,000,000.00) aggregate professional liability coverage with an approved carrier. Individual consideration is given to physicians with Federal Tort Claims Act coverage or in accordance with Mississippi Code Section 11-46-15. Documentation supporting the physician's coverage through these means must be provided. Other individual consideration may be given at the discretion of MPCN.

12.2 Each Participating Physician and MPCN shall maintain such other insurance as shall be necessary to insure each other, their respective agents and employees against damages arising from their respective duties and obligations under this Agreement or that which would impair their individual ability to carry out the terms of the this Agreement.

ARTICLE XIII
General Provisions

13.1 Any notice required by this Agreement shall be given only in written form, sent by United States mail, return receipt requested, with postage prepaid and addressed to MPCN at Post Office Box 1530, Ridgeland, MS 39158-1530 and to Participating Physician at his or her last known address. Notice shall be deemed given on the date of delivery or refusal as shown on the return receipt.

13.2 The invalidity of any term or provision of this Agreement shall not affect the validity of any other term or provision of this Agreement.

13.3 Waiver of a breach of any provision of this Agreement shall not be deemed a waiver of any other breach of the same or different provision.

13.4 This Agreement may be amended only by the written mutual consent of both parties.

13.5 This Agreement shall be binding upon, and shall inure to the benefit of the parties to it, their respective heirs, legal representative, successors and assigns. Notwithstanding the foregoing, neither party may assign any of their respective rights or delegate any of their respective duties hereunder without receiving the prior written consent of the other party.

13.6 Headings are solely for convenience and shall not be used in interpreting the text of this Agreement.

13.7 In the event either party initiates legal action with respect to the interpretation or performance of this Agreement, the prevailing party shall be entitled to reasonable attorney's fees and costs as the court may award.

13.8 MPCN, the Payors and Participating Physicians, their agents and employees respectively, are at all times acting and performing as independent contractors in the performance of their obligations under this Agreement.

13.9 This Agreement shall be governed by and construed in accordance with the laws of the State of Mississippi.

13.10 Both parties agree, solely to the extent applicable to the terms of this agreement to comply with the Healthcare Insurance Portability and Accountability Act of 1996 regulations and rules regarding access to personal information for the transmission of healthcare data including but not limited to the Standards for Electronic Transactions and Code Sets, Privacy and Individually Identifiable Health Information, Security and Electronic Signatures, National Standard Health Care Identifier, and National Standard Employer Identifier. Both parties agree to be in compliance with Standards published as the "Final Rule" in the Federal Register not later than the compliance implementation date furnished by the Department of Health & Human Services.

13.11 This Agreement constitutes the entire agreement between the parties and as of the effective date hereof supersedes all other agreements and understandings between the parties with respect to the subject matter hereof.

ARTICLE XIV
Term and Termination

14.1 This Agreement shall become effective on the date first written above and shall be effective for a period of twelve (12) months thereafter. This Agreement shall automatically be renewed for successive periods of twelve (12) months each on the same terms and conditions contained herein, unless sooner terminated pursuant to the terms of this Agreement.

14.2 Either party may notify the other party in writing of its intention to terminate this Agreement. Such written notice shall be provided at least thirty (30) days prior to the date of termination.

14.3 Notwithstanding any other provision of this Agreement, MPCN shall have the right to cancel this Agreement immediately in the event the Participating Physician shall be determined by MPCN in its sole and absolute discretion to be in violation of or failing to

comply with any of the requirements of this Agreement after thirty (30) days written notice and failure to comply.

14.4 This Agreement will automatically terminate on the earlier of:

(1) The date legislation is effective, or any court interprets a law so as to prohibit the continuation of this Agreement; or

(2) The date on which MPCN or the Participating Physician ceases doing business, or files for protection in the U. S. Bankruptcy Court.

14.5 In the event this Agreement is terminated for any reason, the Payors, under a separate agreement with MPCN, agree to continue to make payments to a Participating Physician in accordance with the terms and conditions of this Agreement for Covered Services rendered.

Mississippi Physicians Care Network

By: _____
Scott Dennis

Title: Chief Executive Officer

Date: _____

Participating Physician

By: _____
Signature

Name: _____
(Please print)

Tax ID #: _____

Date: _____

SCHEDULE A

1. REIMBURSEMENT SCHEDULE

Participating Provider shall submit, within ninety (90) days of date of service to COMPANY, his/her claim for Covered Services rendered to Covered Individuals consistent with Article 2 of this AGREEMENT according to each COMPANY'S contract year. Claims submitted after ninety (90) days from contract year will be denied. Such services shall show gross charges for all Covered Services rendered identified by code as it appears in the current Provider's Current Procedural Terminology (CPT). Claims shall be submitted on standard HCFA 1500 Universal Claims Forms or on other forms or using electronic media acceptable to MPCN.

Participating Provider claims for Covered Services shall be paid within 45 calendar days upon receipt unless one of the following has occurred:

1. The claim form is incomplete or incorrect;

2. Billing of services rendered is not consistent with current CPT;

3. Services rendered are subject to Coordination of Benefits (COB) and/or Utilization Review; or

4. Covered Individual's eligibility is under review.

Companies shall pay to Participating Provider the lesser of his/her usual and customary fee or the MPCN fee maximum for the Covered Service rendered for all services that are payable in accordance with the AGREEMENT.

Payment on all claims shall be subject to medical necessity provisions in the Covered Individual's certificate of coverage and payments for Covered Services rendered to Covered Individuals are to be provided only when the services are based on valid medical needs. The Participating Provider agrees to hold the Covered Individual harmless for fees associated with such Covered Services which have been determined to be medical unnecessary.

2. FEE MAXIMUMS (UCR)

Fee maximums are established for each eligible CPT procedure code submitted. These maximums will be representative of the general experience accumulated for medical services rendered by the network of Participating Providers.

EXHIBIT 1

MOLINA HEALTHCARE OF MISSISSIPPI, INC /MISSISSIPPICAN/CHIP/ MARKETPLACE/MEDICARE ADVANTAGE D-SNP AMENDMENT TO MISSISSIPPI PHYSICIANS CARE NETWORK PHYSICIAN SERVICE AGREEMENT

This Amendment ("Amendment") is entered into by Mississippi Physicians Care Network, Inc. ("MPCN") and _____("Participating Physician"), collectively referred to in this Amendment as the "Parties" or individually as a "Party", as of the Effective Date indicated below.

WHEREAS, MPCN and Participating Physician have previously entered into a Mississippi Physicians Care Network Physician Service Agreement (the "Master Agreement");

WHEREAS, in accordance with such Master Agreement, MPCN has entered into a contract with Molina Healthcare of Mississippi, Inc. ("CCO") so that CCO becomes the Health Plan, as that term is defined in the Agreement;

WHEREAS, CCO has contracted with the state of Mississippi's Division of Medicaid to arrange for the provision of medical services to Beneficiaries under the MississippiCAN Program;

WHEREAS, CCO has contracted with the state of Mississippi's Division of Medicaid to arrange for the provision of medical services to Beneficiaries under the Children's Health Insurance Program ("CHIP");

WHEREAS, CCO intends to offer a Health Insurance Marketplace ("Molina Marketplace") product in the state of Mississippi for the provision of medical services to eligible and qualifying Beneficiaries, in accordance with applicable Laws and Government Program Requirements;

WHEREAS, the Parties desire to amend the Master Agreement to comply with the requirements of both Molina Healthcare of Mississippi, Inc. and the MississippiCAN Program;

NOW THEREFORE, in consideration of the promises and mutual covenants herein contained, the Parties agree as follows:

1.1 The attached "Provider Services Agreement, Molina Healthcare of Mississippi, Inc.", shall be incorporated into the Master Agreement.

1.2 **Full Force and Effect.** Except as set forth in this Amendment, the Master Agreement will remain unaffected and shall continue in full force and effect in accordance with its terms. If there is a conflict between this Amendment and the Master Agreement or an earlier amendment, the terms of this Amendment will prevail.

1.3 **Counterparts.** This Amendment may be executed in one or more counterparts, each of which shall be deemed an original, but all of which taken together shall constitute one and the same instrument.

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Signature Authorization

The Authorized Representative acknowledges, warrants, and represents that the Authorized Representative has the authority and authorization to act on behalf of its Party. The Authorized Representative further acknowledges he/she received and reviewed this Amendment, including the Provider Services Agreement, Molina Healthcare of Mississippi, Inc., in its entirety.

The Authorized Representative of Provider acknowledges the Provider Manual was available for review prior to entering into this Amendment, and agrees that Provider will comply with the provisions set forth under the Provider Manual section and other applicable provisions related to the Provider Manual.

The Authorized Representative of Provider executes this Amendment with the intent to be bound in accordance with this Amendment. **Practitioner agrees to enroll in the following products** (Initial all that apply):

☐ Molina MississippiCAN

☐ Molina Children's Health Insurance Program "CHIP"

☐ Molina Marketplace

☐ Molina Medicare Advantage D-SNP (you must provide Medicare ID number for D-SNP enrollment)

Provider Signature and Information:

Practioners's Legal Name ("Provider"):		
Authorized Representative's Signature:		Authorized Representative's Name – Printed:
Authorized Representative's Title:		Authorized Representative's Signature Date:
Telephone Number:		Fax Number – Official Correspondence:
Mailing Address – Official Correspondence:		Payment Address – If different than Mailing Address:
Individual Medicaid ID:	Individual Medicare ID:	Tax ID Number – As listed on W9:
Individual Practitioner NPI:		Email Address – Official Correspondence:

Network Signature and Information:

Mississippi Physicians Care Network ("MPCN")	
Authorized Representative's Signature:	Authorized Representative's Name – Printed: Scott Dennis
Authorized Representative's Title: CEO	Authorized Representative's Countersignature Date:
	Email Address – Official Correspondence:

Effective Date of Agreement ("effective Date"):

PROVIDER SERVICES AGREEMENT

Molina Healthcare of Mississippi, Inc.

Health Plan and Provider enter into this Agreement as of the Effective Date set forth on the Signature Page of this Agreement. The Provider and Health Plan each are referred to as a "Party" and collectively as the "Parties".

RECITALS

A. WHEREAS, Health Plan is a corporation licensed and approved by required agencies to operate a health care service plan, including without limitation, to issue benefit agreements covering the provision of health care and related services and enter into agreements with Participating Providers;

B. WHEREAS, Provider is approved to provide health care or related services and desires to provide services to eligible recipients; and

C. WHEREAS, the Parties intend by entering into this Agreement they will make health care or related services available to eligible recipients enrolled in various Products covered under this Agreement.

NOW, THEREFORE, in consideration of the promises, covenants, and warranties stated herein, the Parties agree as follows:

ARTICLE ONE – DEFINITIONS

1.1 Capitalized words or phrases in this Agreement have the meaning set forth below.

a. **Advance Directive** means a Member's written instructions, recognized under Law, relating to the provision of health care, when the Member is not competent to make a health care decision as determined under Law.

b. **Affiliate** means an entity owned or controlled by Health Plan or Molina Healthcare, Inc.

c. **Agreement** means this Provider Services Agreement between Provider and Health Plan and all attachments, exhibits, addenda, amendments, and incorporated documents or materials.

d. **Centers for Medicare and Medicaid Services ("CMS")** means the agency responsible for Medicare and certain parts of Medicaid, CHIP, Medicare-Medicaid Program, and the Health Insurance Marketplace.

e. **Claim** means a bill for Covered Services provided by Provider.

f. **Clean Claim** means a Claim for Covered Services submitted on an industry standard form, which has no defect, impropriety, lack of required substantiating documentation, or particular circumstance requiring special treatment that prevents timely adjudication of the Claim.

g. **Covered Services** mean those health care services and supplies, including Emergency Services, provided to Members that are Medically Necessary and are benefits of a Member's Product.

h. **Cultural Competency Plan** means a plan that ensures Members receive Covered Services in a manner that takes into account, but is not limited to, developmental disabilities, physical disabilities, differential abilities, cultural and ethnic backgrounds, and limited English proficiency.

i. **Date of Service** means the date on which Provider provides Covered Services or, for inpatient services, the date the Member is discharged.

j. **Downstream Entity** means any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the Medicare Advantage, Medicaid, or MMP Products, below the level of the arrangement between Health Plan (or applicant) and Provider. These written arrangements continue down to the level of the ultimate provider for health and administrative services.

k. **Emergency Services** mean covered inpatient and outpatient services furnished by a provider who is qualified to furnish these services and such services are needed to evaluate or stabilize an emergency medical condition.

l. **Encounter Data** means all data captured during the course of a single health care encounter that specifies: (i) the diagnoses, comorbidities, procedures (therapeutic, rehabilitative, maintenance, or palliative) pharmaceuticals, medical devices, and equipment associated with a Member receiving services during the

encounter; (ii) the identification of the Member receiving and the provider providing the health care services during the single encounter; and (iii) a unique and unduplicated identifier for the single encounter.

m. **Government Contracts** mean those contracts between Health Plan and state and federal agencies for the arrangement of health care and related services for Government Programs.

n. **Government Programs** mean various government sponsored health products in which Health Plan participates.

o. **Government Program Requirements** mean the requirements of governmental agencies for a Government Program, which includes, but is not limited to, the requirements set forth in the Government Contract.

p. **Grievance Program** means the procedures established by Health Plan to timely address Member and Provider complaints or grievances.

q. **Health Insurance Marketplace** means those health insurance products/programs required by Title I of the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), referred to collectively as the Affordable Care Act, including all implementing statutes and regulations.

r. **Health Plan** means Molina Healthcare of Mississippi, Inc., a Mississippi Corporation.

s. **Law** means all statutes, codes, and regulations applicable to this Agreement.

t. **Medicaid** means the joint federal-state program provided for under Title XIX of the Social Security Act, as amended.

u. **Medically Necessary or Medical Necessity** means health care services provided to a patient for the purpose of evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms and that are: (i) in accordance with generally accepted standards of medical practice; (ii) appropriate for the symptoms, diagnosis, or treatment of the Member's condition, disease, illness or injury; (iii) not primarily for the convenience of the Member or health care provider; and (iv) not more costly than an alternative service, or site of services, at least as likely to produce equivalent results.

v. **Medicare Advantage ("MA")** means a program in which private health plans provide health care and related services through a Government Contract with CMS, which is authorized under Title XVIII of the Social Security Act, as amended (otherwise known as "Medicare"). Medicare Advantage also includes Medicare Advantage Special Needs Plans ("MA-SNP").

w. **Medicare-Medicaid Program ("MMP")** means a program in which private health plans provide health care and related services to beneficiaries eligible for both Medicaid and Medicare through a Government Contract with CMS and the State.

x. **Member** means a person enrolled in a Product and who is eligible to receive Covered Services.

y. **Molina Marketplace** means the Products offered and sold by Health Plan under the requirements of the Health Insurance Marketplace.

z. **Overpayments** mean a payment Provider receives, which after applicable reconciliation, Provider is not entitled to receive pursuant to Laws, Government Program Requirements, or this Agreement.

aa. **Participating Provider** means a healthcare facility or practitioner contracted with and, as applicable, credentialed by Health Plan or Health Plan's designee.

bb. **Product** means the various health insurance programs offered by Health Plan to Members in which Provider agrees to be a Participating Provider, identified on Attachment A, Products, and which will include any successors to such Products.

cc. **Provider** means the entity identified on the Signature Page of this Agreement and includes any person or entity performing Covered Services on behalf of Provider and for which: (i) an entity of the Provider bills under an owned tax identification number; and (ii), when applicable, such person or entity has been approved by Health Plan as a Participating Provider. Each entity or person shall be considered an "Individual Provider".

dd. **Provider Manual** means Health Plan's provider manuals, policies, procedures, documents, educational materials, and, as applicable, Supplemental Materials, setting forth Health Plan's requirements and rules that Provider is required to follow.

ee. **Quality Improvement Program ("QI Program")** means the policies and procedures, interventions, and systems, developed by Health Plan for monitoring, assessing, and improving the accessibility, quality, and continuity of care provided to Members.

ff. **Responsible Entity** means an entity that is financially responsible for certain Covered Services and pays Claims that are part of its financial responsibility.

gg. **State Children's Health Insurance Program ("SCHIP" or "CHIP")** means the program established pursuant to Title XXI of the Social Security Act, as amended.

hh. **Subcontractor** means an individual or organization, including Downstream Entity, with which Provider contracts for the provision of Covered Services or administrative functions related to the performance of this Agreement. For the avoidance of doubt, a Subcontractor does not include Individual Providers.

ii. **Utilization Review and Management Program ("UM Program")** means the policies, procedures, and systems developed by Health Plan for evaluating and monitoring the Medical Necessity, appropriateness, efficacy, or efficiency of core health care benefits and services, procedures or settings and ambulatory review, prospective review, concurrent review, second opinions, care management, discharge planning, or retrospective reviews, including, but not limited to, under-utilization and over-utilization.

ARTICLE TWO – PROVIDER OBLIGATIONS

2.1 **Provider Standards.**

a. **Standard of Care.** Provider agrees to provide Covered Services within the scope of Provider's business. Provider will ensure all services and interactions with Members are at a level of care and competence that equals or exceeds generally accepted and professionally recognized standards of practice, rules, and standards of professional conduct, Laws and Government Program Requirements.

b. **Facilities, Equipment, and Personnel.** Provider's facilities, equipment, personnel, and administrative services will be at a level and quality necessary to perform Provider's duties and responsibilities under this Agreement and to comply with Laws and Government Program Requirements.

c. **Prior Authorization.** For Covered Services that require prior authorizations, Provider will obtain prior authorization from Health Plan before providing such Covered Service. Provider will not have to obtain prior authorizations before providing Emergency Services.

d. **Use of Participating Providers.** Except in the case of Emergency Services or when Provider obtains prior authorization, Provider will only utilize Participating Providers to provide Covered Services. If a Participating Provider is not available, Provider will notify Health Plan so Health Plan can determine the appropriate provider to perform such services.

e. **Prescriptions.** When prescribing medications that a Member gets through a pharmacy, Provider will follow Health Plan's Drug Formulary/Prescription Drug List, and prior authorization and prescription policies. Provider acknowledges the authority of pharmacies to substitute generics or low cost alternative prescriptions for the prescribed medication.

f. **Provider-Member Communication.** Health Plan encourages open Provider-Member communication regarding Medical Necessity, appropriate treatment, and care. Provider is free to communicate all treatment options to Members regardless of limitations on Covered Services.

g. **Member Eligibility Verification.** Provider will verify eligibility of Members before providing services unless the situation involves the provision of Emergency Services.

h. **Availability of Services.** Provider will make necessary and appropriate arrangements to ensure availability of Covered Services twenty-four (24) hours a day, seven (7) days a week. Provider will meet applicable standards for timely access to care and service in accordance with Laws and Government Program Requirements.

i. **Admission Notifications.** Provider will notify Health Plan of Member hospital admissions, including inpatient admissions and Members referred to the emergency department, no later than twenty-four (24) hours after such admission.

j. **Staffing Privileges for Providers.** Provider will have staff privileges with at least one (1) Health Plan contracted hospital as necessary to provide Covered Services. Provider will authorize each hospital to notify Health Plan if disciplinary or other action of any kind is initiated against Provider, which could result in the suspension, reduction, or modification of Provider's hospital privileges. If Provider does not have staff privileges with at least one (1) Health Plan contracted hospital, Provider must provide an acceptable arrangement to Health Plan that ensures Member continuity of care.

2.2 **Rights of Members.** Provider will observe, protect, and promote the rights of Members.

2.3 **Use of Name.** Provider will display Health Plan's promotional materials as practical and will cooperate in reasonable Health Plan marketing efforts that do not violate Laws or Government Program Requirements. Provider will not use Health Plan's name in advertising or promotional materials without the prior written consent of Health Plan. Health Plan may use Provider's name and related information in: (i) publications to identify Provider as a Participating Provider; and (ii) as may be required to comply with the Laws and Government Program Requirements.

2.4 **Non-Discrimination in Enrollment.** Provider will not differentiate or discriminate in providing Covered Services because of race, color, religion, national origin, ancestry, age, sex, marital status, sexual orientation, physical, sensory or mental handicap, socioeconomic status, or participation in publicly financed programs of health care services. Provider will provide Covered Services in the same location, in the same manner, in accordance with the same standards, and within the same time or availability, regardless of payer.

2.5 **Recordkeeping.**

a. **Maintaining Member Record.** Provider will maintain a medical and billing record ("Record") for each Member to whom Provider provides health care services. The Member's Record will contain all information required by Laws, generally accepted and prevailing professional practices, applicable Government Program Requirements, and Health Plan's policies and procedures. Provider will retain such Record for as long as required by Laws and Government Program Requirements. This section will survive any termination.

b. **Confidentiality of Member Record.** Provider will comply with all Laws, including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Health Information Technology for Economic and Clinical Health ("HITECH") Act, Health Plan's policies and procedures, and Government Program Requirements regarding privacy and confidentiality. Provider will not disclose or use Member names, addresses, social security numbers, identities, other personal information, treatment modalities, or Record without obtaining appropriate authorization. This section does not affect or limit Provider's obligation to make available the Record, Encounter Data, and information concerning Member care to Health Plan, a state or federal agency, or another provider of health care. This section will survive any termination.

c. **Delivery of Member Information.** Provider will promptly deliver to Health Plan, upon request or as may be required by Laws, Health Plan's policies and procedures, Government Program Requirements, or third party payers, any information, statistical data, Encounter Data, or Record pertaining to a Member. Provider is responsible for the fees associated with producing the above items. Provider will further give direct access to the items as requested by Health Plan or as required by a state or federal agency. Health Plan has the right to withhold compensation from Provider if Provider fails or refuses to give the items to Health Plan promptly. This section will survive any termination.

d. **Member Access to Member Record.** Provider will give Members access to Members' Record and other applicable information, in accordance with Laws, Government Program Requirements, and Health Plan's policies and procedures. This section will survive any termination.

2.6 **Program Participation.**

a. **Participation in Grievance Program.** Provider will participate in and comply with Health Plan's Grievance Program, and will cooperate with Health Plan in identifying, processing, and resolving Member grievances, complaints, or inquiries.

b. **Participation in Quality Improvement Program.** Provider will participate in and comply with Health Plan's QI Program, and will cooperate in conducting peer reviews and audits of care provided by Provider.

c. **Participation in Utilization Review and Management Program.** Provider will participate in and comply with Health Plan's UM Program. Provider will cooperate with Health Plan in audits to identify, confirm, and assess utilization levels of Covered Services.

d. **Participation in Credentialing.** Provider will participate in and satisfy credentialing criteria established by Health Plan before the Effective Date and throughout the term of this Agreement. Provider will promptly notify Health Plan in writing of any change in the information submitted or relied upon by Provider to achieve or maintain credentialed status. In accordance with Health Plan's policies and procedures, Provider must be credentialed by Health Plan or Health Plan's designee before providing Covered Services.

e. **Health Education/Training.** Provider will participate in and comply with Health Plan's Provider education and training efforts, which includes the Cultural Competency Plan and such standards, policies, and procedures as may be necessary for Health Plan to comply with Laws and Government Program Requirements.

2.7 **Provider Manual.** Provider will comply with the Provider Manual, which is incorporated by reference into this Agreement and may be unilaterally amended from time to time by Health Plan. Provider acknowledges the Provider Manual is available to Provider at Health Plan's website. A physical copy of the Provider Manual is available upon request.

2.8 **Supplemental Materials.** Health Plan may periodically issue bulletins or other written materials in order to supplement the Provider Manual or to give additional instruction, guidance, or information ("Supplemental Materials"). Health Plan may issue Supplemental Materials in an electronic format, which includes, but is not limited to, posting on Health Plan's interactive web-portal, and a physical copy is available upon request. Supplemental Materials become binding upon Provider as of the effective date indicated on the Supplemental Materials or, if applicable, the effective date will be determined in accordance with this Agreement.

2.9 **Health Plan's Electronic Processes and Initiatives.** Provider will participate in and comply with Health Plan's electronic processes and initiatives, including, but not limited to, electronic submission of prior authorization, access to electronic medical records, electronic claims filing, electronic data interchange ("EDI"), electronic remittance advice, electronic fund transfers, and registration and use of Health Plan's interactive web-portal.

2.10 **Information Reporting and Changes.** Provider will deliver to Health Plan a complete list of all health care providers, facilities, and business/practice locations it uses to provide Covered Services every thirty (30) days, together with specific information required for credentialing and administration. If Provider does not deliver such information, Health Plan will use the last information received from Provider. Notwithstanding the above, if a Law or Government Program Requirement requires the delivery of information described in this section in another matter or different timeframe, Provider will notify Health Plan in accordance with the Law or Government Program Requirement. Health Plan also reserves the right to request such information at any time.

2.11 **Standing.**

a. **Licensure.** Provider warrants and represents it has the appropriate licenses to provide Covered Services. This includes having and maintaining a current narcotics number issued by proper authorities when appropriate. Provider will deliver evidence of licensure to Health Plan upon request. Provider will maintain its licensure in good standing, free of disciplinary action, and in unrestricted status. Provider will promptly notify Health Plan of changes in its licensure status, including, but not limited to, disciplinary action taken or proposed by any agency responsible for oversight of Provider.

b. **Unrestricted Status.** Provider represents to its best knowledge, information, and belief, neither it, nor any of its employees, temporary employees, volunteers, consultants, members of its board of directors, officers, or contractors (collectively, "Personnel") have been excluded from participation in the Medicare Program, any state, commonwealth, or the District of Columbia's Medicaid Program, or any other federal health care program (collectively "Federal Health Care Program"). Provider agrees that it must check the Department of Health and Human Services Office of Inspector General List of Excluded Individuals and Entities, the System for Award Management, any other list maintained by a state, commonwealth, or federal government, and every state, commonwealth, and the District of Columbia's Medicaid exclusion lists to determine whether Provider or any

of its Personnel have been excluded from participation in any Federal Health Care Program. These databases must be checked for any new Personnel and thereafter not less than monthly. Provider will notify Health Plan immediately in writing if Provider determines that Provider or any of its Personnel are suspended or excluded from any Federal Health Care Program. Provider agrees that it is subject to 2 CFR Part 376 and will require its Personnel to agree that they are subject to 2 CFR Part 376. If a governmental agency imposes a penalty, sanction, or other monetary adjustment or withhold due to Provider's non-compliance with this provision or any payments were made to Provider while under non-compliance with this provision, Health Plan may collect the amount: (i) by offsetting from amounts due to Provider; or (ii) Health Plan may issue a recoupment letter and Provider agrees it will remit funds pursuant to the terms of the recoupment letter. If required, such offset or recoupment will be done in a manner that is compliant with Laws and Government Program Requirements. This section will survive any termination.

c. **Malpractice and Other Actions.** Provider will give prompt written notice to Health Plan of: (i) a malpractice claim asserted against it by a Member, a payment made by or on behalf of Provider in settlement or compromise of such a claim, or a payment made by or on behalf of Provider pursuant to a judgment rendered upon such a claim; (ii) a criminal investigation or proceeding against Provider; (iii) a conviction of Provider for crimes involving moral turpitude or felonies; and (iv) a civil claim asserted against Provider that may jeopardize Provider's financial soundness. This section will survive any termination.

d. **Liability Insurance.** Provider will maintain general and professional liability insurance in coverage amounts appropriate for the size and nature of Provider's facility and health care activities, and in compliance with Laws and Government Program Requirements. If the coverage is claims made or reporting, Provider agrees to purchase similar "tail" coverage upon termination of the Provider's present or subsequent policy. Provider will deliver copies of such insurance policy to Health Plan within five (5) business days of a written request by Health Plan. Provider will deliver advance written notice fifteen (15) business days before any change, reduction, cancellation, or termination of such insurance coverage. This section will survive any termination.

2.12 **Non-Solicitation of Members.** Provider will not solicit or encourage Members to select another health plan.

2.13 **Laws and Government Program Requirements.**

a. **Compliance with Laws and Government Program Requirements.** Provider will comply with Laws that are applicable to this Agreement. Provider acknowledges Health Plan entered into Government Contracts and Provider will comply with the applicable Government Program Requirements that must be satisfied under this Agreement. Upon written request, Health Plan will give Provider a redacted copy of applicable Government Contracts.

b. **Fraud and Abuse Reporting.** Provider will comply with Laws and Government Program Requirements related to fraud, waste, and abuse. Provider will establish and maintain policies and procedures for identifying and investigating fraud, waste, and abuse. In the event Provider discovers an occurrence of fraud, waste, or abuse, Provider will promptly notify Health Plan. Provider will participate in investigations conducted by Health Plan or by state or federal agencies. This section will survive any termination.

c. **Advance Directive.** Provider will comply with Laws and Government Program Requirements related to Advance Directives.

d. **Ownership Disclosure Information.** If applicable, Provider must disclose to Health Plan the name and address of each person, entity, or business with an ownership or control interest in the disclosing entity before the Effective Date and throughout the term of this Agreement. Provider or disclosing entity must also disclose to Health Plan whether any person, entity, or business with an ownership or control interest in the disclosing entity are related to another as spouse, parent, child, or sibling before the Effective Date and throughout the term of this Agreement. Furthermore, there must be disclosure of the name of any other disclosing entity in which a person with an ownership or controlling interest in the Provider or disclosing entity also has an ownership or control interest.

2.14 **Reciprocity Agreements.** Provider will cooperate with Affiliates and agrees to ensure reciprocity of health care services to Affiliate's enrollees. For Affiliate enrollees, Provider will be compensated for Clean Claims that are determined to be payable in accordance with Laws and Government Program Requirements. If there is not a Law or

Government Program Requirement governing reimbursement, Provider will be compensated at the rates set forth in this Agreement. Provider will follow the hold harmless provisions of this Agreement for Affiliate's enrollees.

2.15 **Transfer of Members.** Provider will not unilaterally assign or transfer Members to another Participating Provider or non-Participating Provider without the prior written approval of Health Plan.

2.16 **Members Condition Changes.** Upon becoming aware of a significant change in a Member's health or functional status, a Member is being abused or neglected, or a Member death, Provider will notify Health Plan's Member Services department as soon as possible, but not later than seven (7) days.

ARTICLE THREE – HEALTH PLAN'S OBLIGATIONS

3.1 **Member Eligibility Determination.** Health Plan will maintain data on Member eligibility and enrollment. Health Plan will promptly verify Member eligibility at the request of Provider.

3.2 **Prior Authorization Review.** Health Plan will respond with a determination on a prior authorization request in accordance with the time frames governed by Laws and Government Program Requirements after receiving all necessary information from Provider.

3.3 **Medical Necessity Determination.** Health Plan's determination with regard to Medical Necessity, including, but not limited to, determinations of level of care and length of stay, will govern. The primary concern with respect to Medical Necessity determinations is the interest of the Member.

3.4 **Member Services.** Health Plan will provide services to Members, including, but not limited to, assisting Members in selecting a primary care physician, processing Member complaints and grievances, informing Members of Health Plan's policies and procedures, providing Members with membership cards, providing Members with information about Health Plan, and providing Members with access to Health Plan's Provider Directory.

3.5 **Provider Services.** Health Plan will make available a provider services department that, among other Health Plan duties, is available to assist Provider with questions about this Agreement.

3.6 **Corrective Action.** Health Plan, and state and federal agencies routinely monitor the level, manner, and quality of Covered Services provided as well as Provider's compliance with this Agreement. If a deficiency is identified, Health Plan or an agency, in its sole discretion, may choose to issue a corrective action plan. Provider is required to accept and implement such corrective action plan. Provider is not entitled to a corrective action plan prior to any termination.

3.7 **Reassignment of Members.** Health Plan reserves the right to reassign, limit, or deny the assignment or selection of Members to Provider if Health Plan determines that Provider poses a threat to Members' health and safety or during a termination notice period. If Provider requests reassignment of a Member, Health Plan, in its sole discretion, will make the determination regarding reassignment based upon good cause shown by the Provider. When Health Plan reassigns Member, Provider will forward copies of the Member's medical records to the new provider within ten (10) business days of receipt of the Health Plan's or the Member's request to transfer the records.

3.8 **Quality Bonus Payment Program.** Health Plan may offer Provider the opportunity to participate in Health Plan's Quality Bonus Payment Program ("QBPP"). If offered, the QBPP will promote quality of care. Payments under the QBPP are available to Provider based on qualifying criteria and events as described in the Provider Manual and related Supplemental Materials. QBPP payments are not guaranteed and are paid separately from and in addition to the compensation terms of this Agreement.

a. **Eligibility**. To be eligible for the QBPP, Provider must register with Health Plan's interactive web portal. Additionally, Provider must remain in full compliance with this Agreement, which includes, but is not limited, timely and accurate submission of Clean Claims and/or Encounter Data, and remittance of funds due to Health Plan under this Agreement. QBPP documentation submitted by Provider is subject to audit by Health Plan and the program is subject to Laws and Government Program Requirements.

b. **Terms and Conditions.** QBPP payments are subject to terms set forth in the program, which may be modified at any time by Health Plan without notice or amendment. Modifications may include, but are not limited to, exclusions or removal of measures from the program and changes to the calculation and payment methodologies. In the event of a conflict between the Agreement and QBPP, the QBPP will prevail.

ARTICLE FOUR – CLAIMS PAYMENT

4.1 **Claims.** Provider will promptly submit to Health Plan Claims for Covered Services in a standard form that is acceptable to Health Plan. Provider is not eligible for payment on Claims submitted after one hundred and eighty (180) days from the Date of Service, unless Health Plan is required to follow a different timeframe pursuant to a Law or Government Program Requirement. When Health Plan is the secondary payer, Provider is not eligible for payment for Claims submitted after one hundred and eighty (180) days from the date the primary payer adjudicated the Claim, unless Health Plan is required to follow a different timeframe pursuant to a Law or Government Program Requirement. Provider will include all medical records pertaining to the Claim if requested by Health Plan and as may be required by Health Plan's policies and procedures.

4.2 **Compensation.** Health Plan will pay Provider for Clean Claims for Covered Services, that are determined to be payable, in accordance with Laws, Government Program Requirements, and this Agreement. Health Plan will make such payment within sixty (60) days, unless otherwise required by Laws or Government Program Requirements. Provider agrees to accept such payments, applicable co-payments, co-insurances, deductibles, and coordination of benefits collections as payment in full for Covered Services. Provider's failure to comply with the terms of this Agreement may result in non-payment to Provider.

4.3 **Co-payments and Deductibles.** Provider is responsible for collection of co-payments, co-insurances, and deductibles, if any.

4.4 **Member Hold Harmless.** Provider agrees in no event, including, but not limited to, non-payment, insolvency, or breach of this Agreement by Health Plan, will Provider bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against a Member or person acting on Member's behalf, for Covered Services provided pursuant to this Agreement. This does not prohibit Provider from collecting co-payments, co-insurances, or deductibles as specifically provided in the Member's evidence of coverage or fees for non-Covered Services. This section will survive any termination, regardless of the reason for the termination, including insolvency of Health Plan.

4.5 **Coordination of Benefits.** Health Plan is a secondary payer where another payer is primary payer. Provider will make reasonable inquiry of Members to learn if Member has health insurance or health benefits other than from Health Plan, or is entitled to payment by a third party under any other insurance or plan of any type. Provider will promptly notify Health Plan of said entitlement. In the event a coordination of benefits occurs, Provider will be compensated in an amount equal to the allowable Clean Claim less the amount paid by other health plans, insurance carriers, and payers, not to exceed the amount specified in the Compensation Schedule of this Agreement.

4.6 **Offset.** In the event of an Overpayment, Health Plan may recover the amount owed by: (i) recoupment; or (ii) by way of offset from current or future amounts due Provider. If required, such recoupment or offset will be done in a manner that is compliant with Laws and Government Program Requirements. As a material condition to Health Plan's obligations under this Agreement, Provider agrees the offset and recoupment rights set forth in this Agreement will be deemed to be and to constitute rights of offset and recoupment authorized under Law or in equity to the maximum extent legally permissible. Such rights will not be subject to any requirement of prior or other approval from a court or other governmental agency that may now or hereafter have jurisdiction over Health Plan or Provider. This section will survive any termination.

4.7 **Claim Review.** Claims will be reviewed and paid in accordance with industry standard billing and payment rules, including, but not limited to, Uniform Billing ("UB") manual and editor, Current Procedural Terminology ("CPT") and Healthcare Common Procedure Coding System ("HCPCS"), federal and state billing and payment rules, National Correct Coding Initiatives ("NCCI") Edits, and Federal Drug Administration ("FDA") definitions and determinations of designated implantable devices and implantable orthopedic devices. Furthermore, Provider acknowledges Health Plan's right to conduct Medical Necessity reviews and apply clinical practice standards to determine appropriate payment. Payment may exclude certain items not billed in accordance with industry standard billing and payment rules or that do not meet Medical Necessity criteria. This section will survive any termination.

4.8 **Claim Auditing.** Provider acknowledges Health Plan's right to conduct post-payment billing audits. Provider will cooperate with Health Plan's audits of claims and payments by providing access at reasonable times to requested claims information, all supporting medical records, Provider's charging policies, and other related data. Health Plan will use established industry claims adjudication, and clinical practices, state and federal guidelines, and Health

Plan's policies and data to determine the appropriateness of the billing, coding, and payment. This section will survive any termination.

4.9 **Financially Responsible Entity Payments.** If Provider provides Covered Services that are the responsibility of a Responsible Entity, Provider will look solely to the Responsible Entity for payment of such Covered Services. Pursuant to Health Plan's contract with Responsible Entity, Responsible Entity is to compensate Provider at the rate set forth in Provider's contract with Responsible Entity. If Responsible Entity and Provider do not have a contract or have not agreed to compensation terms, Provider will be reimbursed, as determined by Provider and Responsible Entity, at: (i) one hundred percent (100%) of the governing rates provided by Law specific to the Member's Product in place on the Date of Service; or (ii) at the rates set forth in this Agreement specific to the Member's Product in place on the Date of Service. Except as specifically stated in this section, Provider agrees that the compensation provisions of this Agreement will be binding upon Provider and that Provider will follow the hold harmless provisions of this Agreement.

4.10 **Timely Submission of Encounter Data.** Provider understands Health Plan may have certain contractual reporting obligations that require timely submission of Encounter Data. If a Clean Claim does not contain the necessary Encounter Data, Provider will submit Encounter Data to Health Plan. This section will survive any termination.

ARTICLE FIVE – TERM AND TERMINATION

5.1 **Term.** This Agreement will commence on the Effective Date indicated by Health Plan and will continue in effect until terminated by either Party in accordance with the provisions of this Agreement.

5.2 **Termination without Cause.** This Agreement, an individual Product, or an Individual Provider under this Agreement, may be terminated without cause at any time by either Party by giving at least one hundred and twenty (120) days prior written notice to the other Party.

5.3 **Termination with Cause.** In the event of a breach of a material provision of this Agreement, the Party claiming the breach will give the other Party written notice of termination setting forth the facts underlying its claim that the other Party breached this Agreement. The Party receiving the notice of termination will have thirty (30) days from the date of receipt of such notice to remedy or cure the claimed breach to the satisfaction of the other Party. During this thirty (30) day period, the Parties agree to meet as reasonably necessary and to confer in an attempt to resolve the claimed breach. If the Party receiving the notice of termination has not remedied or cured the breach within such thirty (30) day period, the Party who delivered the notice of termination has the right to immediately terminate this Agreement, or an individual Product or an Individual Provider under this Agreement, upon expiration of the thirty (30) day period. Notwithstanding the forgoing, either Party may immediately terminate this Agreement, an individual Product, or an Individual Provider under this Agreement, without providing the other Party the opportunity to cure a material breach should the terminating Party reasonably believe the material breach of this Agreement to be non-curable.

5.4 **Immediate Termination.** Notwithstanding any other provision of this Agreement, this Agreement, an individual Product, or an Individual Provider under this Agreement, may immediately be terminated upon written notice to the other Party in the event any of the following occurs:

a. Provider's license or any other approvals needed to provide Covered Services is limited, suspended, or revoked or disciplinary proceedings are commenced against Provider by applicable regulators and accrediting agencies;

b. Either Party fails to maintain adequate levels of insurance;

c. Provider has not or is unable to comply with Health Plan's credentialing requirements, including, but not limited to, having or maintaining credentialing status;

d. Either Party becomes insolvent or files a petition to declare bankruptcy or for reorganization under the bankruptcy laws of the United States, or a trustee in bankruptcy or receiver for Provider or Health Plan is appointed by appropriate authority;

e. If Provider is capitated and Health Plan determines Provider is financially incapable of bearing capitation or other applicable risk-sharing compensation methodology;

f. Health Plan reasonably determines that Provider's facility or equipment is insufficient to provide Covered Services;

g. Either Party is excluded from participation in state or federal health care programs;

h. Provider is terminated as a provider by any state or federal health care program;

i. Either Party engages in fraud or deception, or permits fraud or deception by another in connection with each Party's obligations under this Agreement;

j. Health Plan reasonably determines that Covered Services are not being properly provided, or arranged for by Provider, and such failure poses a threat to Members' health and safety;

k. Provider violates any state or federal law, statute, rule, regulation or executive order; or

l. Provider fails to satisfy the terms of a corrective action plan.

5.5 **Notice to Members.** In the event of any termination, Health Plan will give reasonable advance notice to Members who are currently receiving care in accordance with Laws and Government Program Requirements.

5.6 **Transfer Upon Termination.** In the event of any termination, Health Plan may transfer Members to another provider.

ARTICLE SIX – GENERAL PROVISIONS

6.1 **Indemnification.** Each Party will indemnify and hold harmless the other Party and its officers, directors, shareholders, employees, agents, and representatives from any and all liabilities, losses, damages, claims, and expenses of any kind, including costs and attorneys' fees, which result from the duties and obligations of the indemnifying Party or its officers, directors, shareholders, employees, agents, and representatives under this Agreement.

6.2 **Relationship of the Parties.** Nothing contained in this Agreement is intended to create, nor will it be construed to create, any relationship between the Parties other than that of independent parties contracting with each other solely for the purpose of effectuating this Agreement. This Agreement is not intended to create a relationship of agency, representation, joint venture, or employment between the Parties. Nothing herein contained will prevent the Parties from entering into similar arrangements with other parties. Each Party will maintain separate and independent management and will be responsible for its own operations. Nothing contained in this Agreement is intended to create, nor will it be construed to create, any right in any third party to enforce this Agreement.

6.3 **Governing Law.** The laws of the State of Mississippi will govern this Agreement.

6.4 **Entire Agreement.** This Agreement, including attachments, addenda, amendments, Supplemental Materials, and incorporated documents or materials, contains the entire agreement between the Parties relating to the rights granted and obligations imposed by this Agreement. Any prior agreements, promises, negotiations, or representations, either oral or written, between the Parties and relating to the subject matter of this Agreement, are of no force or effect.

6.5 **Severability.** If a term, provision, covenant, or condition of this Agreement is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remaining provisions will remain in full force and effect and will in no way be affected, impaired, or invalidated as a result of such decision.

6.6 **Headings and Construction.** The headings in this Agreement are for reference purposes only and are not considered a part of this Agreement in construing or interpreting its provisions. It is the Parties' desire that if a provision of this Agreement is determined to be ambiguous, then the rule of construction that such provision is construed against its drafter will not apply to the interpretation of the ambiguous provision. The following rules of construction apply to this Agreement: (i) the word "day" means calendar day unless otherwise specified; (ii) the term "business day" means Monday through Friday, except federal holidays; (iii) all words used in this Agreement will be construed to be of such gender or number as circumstances require; (iv) references to specific statutes, regulations, rules or forms, such as CMS-1500, include subsequent amendments or successors to them; and (v) references to any government department or agency include any successor departments or agencies.

6.7 **Non-exclusivity.** This Agreement will not be construed to be an exclusive Agreement between the Parties. Nor will it be deemed to be an Agreement requiring Health Plan to refer Members to Provider.

6.8 **Amendments.**

a. **Regulatory Amendments.** Health Plan may immediately amend this Agreement to maintain consistency or compliance with applicable policy, directive, Law, or Government Program Requirement at any time and without Provider's consent. Such regulatory amendment will be binding upon Provider.

b. **Non-Regulatory Amendments.** Notwithstanding the Regulatory Amendments section, Health Plan may otherwise amend this Agreement upon thirty (30) days prior written notice to Provider. If Provider does not deliver a written disapproval to such amendment within the thirty (30) day period, the amendment will be deemed accepted by and binding upon Provider. If Health Plan receives a written disapproval within the thirty (30) day period, the Parties agree to meet and confer in good faith to determine if a revised amendment can be accepted by and binding upon the Parties.

6.9 **Delegation or Subcontract.** Upon the Effective Date, Provider will submit to Health Plan a list identifying each of Provider's Subcontractors and a description of the Covered Services or administrative services that the Subcontractor provides. After the Effective Date, Provider will not subcontract with a Subcontractor without the prior written consent of Health Plan. Such arrangement with a Subcontractor will be in writing and will bind Subcontractor to the terms required by Health Plan.

6.10 **Assignment.** Provider may not assign or transfer, in whole or in part, any rights, duties, or obligations under this Agreement without the prior written consent of Health Plan. Subject to the foregoing, this Agreement is binding upon, and inures to the benefit of the Parties and respective successors in interest and assignees.

6.11 **Dispute Resolution.**

a. **Meet and Confer.** Any claim or controversy arising out of or in connection with this Agreement will first be resolved, to the extent possible, via "Meet and Confer". The Meet and Confer will begin when one Party delivers written notice to the other that it intends to arbitrate a dispute and the basis for its belief that it will prevail in arbitration. After providing notice of the intent to arbitrate, the Meet and Confer will be held as an informal face-to-face meeting held in good faith between appropriate representatives of the Parties and at least one (1) person authorized to settle outstanding claims and pending arbitration matters. The Parties will commence the face-to-face portion of the Meet and Confer within forty-five (45) days of receiving notice of an intent to arbitrate or service of an arbitration demand. Such face-to-face Meet and Confer discussion will occur at a time and location agreed to by the Parties (within the forty-five (45) days) and if both Parties agree that more face-to-face discussions would be beneficial, the Parties can agree to have more than one (1) in person settlement discussion or a combination of in person, phone meetings and exchange of correspondence.

b. **Binding Arbitration.** The Parties agree that any dispute not resolved via Meet and Confer will be settled in binding arbitration administered by Judicial Arbitration and Mediation Services ("JAMS"), or if mutually agreed upon, pursuant to another agreed upon Alternative Dispute Resolution ("ADR") provider in accordance with that ADR provider's Commercial Arbitration Rules, in Jackson, Mississippi. However, matters that primarily involve Provider's professional competence or conduct i.e., malpractice, professional negligence, or wrongful death will not be eligible for arbitration.

Any arbitration in which the total amount disputed by one Party is equal to or exceeds one million dollars ($1,000,000.00) will be resolved by a panel of three (3) arbitrators. In the event a panel of three (3) arbitrators will be used, the claimant will select one (1) arbitrator; the respondent will select one (1) arbitrator; and the two (2) arbitrators selected by the claimant and respondent will select the third arbitrator whose determination will be final and binding on the Parties. If possible, each arbitrator will be an attorney with at least fifteen (15) years of experience, including at least five (5) years of experience in managed health care.

Any arbitration in which the total amount disputed by one Party is equal to or exceeds five hundred thousand dollars ($500,000.00), but less than one million dollars ($1,000,000.00), the claimant and respondent will each select a single arbitrator and the two (2) arbitrators selected by the claimant and respondent will select a single arbitrator who will be responsible for the arbitration proceedings ("Selected Arbitrator"). Each Party can strike no more than one (1) Selected Arbitrator. The Selected Arbitrator will be an attorney with at least fifteen (15) years of experience, including at least five (5) years of experience in managed health care.

Any arbitration in which the total amount disputed by one Party is less than five hundred thousand dollars ($500,000.00) will be resolved by a single arbitrator. In the event a single arbitrator is used, the arbitrator will

be an attorney with at least fifteen (15) years of experience, including at least five (5) years of experience in managed health care.

The arbitrator will apply Mississippi substantive law and Federal substantive law where State law is preempted. Civil discovery for use in such arbitration may be conducted in accordance with federal rules of civil procedure and federal evidence code, except where the Parties agree otherwise. The arbitrator selected will have the power to enforce the rights, remedies, duties, liabilities, and obligations of discovery by the imposition of the same terms, conditions, and penalties as can be imposed in like circumstances in a civil action by a court in the same jurisdiction. The provisions of federal rules of civil procedure concerning the right to discovery and the use of depositions in arbitration are incorporated herein by reference and made applicable to this Agreement. However, in any arbitration in which the total amount disputed by one Party is less than one million dollars ($1,000,000.00) the Parties agree that each Party will have the right to take no more than three (3) depositions of individuals or entities, excluding deposition of expert witnesses, and the Parties agree to exchange copies of all exhibits and demonstrative evidence to be used at the arbitration prior to the arbitration as deemed appropriate by the arbitrator. The Parties agree that in any arbitration in which the total amount disputed by one Party is less than five hundred thousand dollars ($500,000.00) each Party will have the right to take no more than one (1) deposition of individuals or entities and one (1) expert witness, and the Parties agree to exchange copies of all exhibits and demonstrative evidence to be used at the arbitration prior to the arbitration as deemed appropriate by the arbitrator. Regardless of the amount in dispute, rebuttal and impeachment evidence need not be exchanged until presented at the arbitration hearing.

The arbitrator will have no authority to give a remedy or award damages that would not be available to such prevailing Party in a court of law, nor will the arbitrator have the authority to award punitive or liquidated damages. The arbitrator will deliver a written reasoned decision within thirty (30) days of the close of arbitration, unless an alternate agreement is made during the arbitration. The Parties agree to accept any decision by the arbitrator, which is grounded in applicable law, as a final determination of the matter in dispute, and judgment on the award rendered by the arbitrator may be entered in any court having jurisdiction. The award may be reviewed, vacated, or modified pursuant to the Federal Arbitration Act ("FAA"), 9 USC sections 9-11. Grounds for vacating an award, include where the award was procured by corruption, fraud, or undue means, and where the arbitrators were guilty of misconduct, exceeded their powers, evident material miscalculation, evident material mistake, imperfect(ions) in (a) matter of form not affecting the merits, and where a decision is not grounded in applicable law. When a decision is not grounded in applicable law, any Party will have the right to appeal the decision in addition to those rights to vacate or appeal already existing pursuant to the FAA or applicable state arbitration laws. Any such appeal may be made to a court having jurisdiction over the Parties or the dispute. Notice of intent to Appeal based on failure to render a decision grounded in law must be given to the other Party within fifteen (15) days after the decision is communicated to the Parties; and the appeal must be formally initiated by filing in court within thirty (30) days after the decision is communicated to the Parties. If a court decides it will not hear an appeal because it deems appeals from arbitration not subject to appeal, there is no right for any additional appeal in any other venue.

Each Party shall bear its own costs and expenses, including its own attorneys' fees, and shall bear an equal share of the arbitrator and administrative fees of arbitration. The parties agree that one or the other may request a court reporter transcribe the entire proceeding, in which case the parties will split the cost of the court reporter, but each may elect to purchase or forego purchasing a transcript.

Arbitration must be initiated within one (1) year of the earlier of the date the claim or controversy arose, was discovered, or should have been discovered with reasonable diligence; otherwise it will be deemed waived. The use of binding arbitration will not preclude a request for equitable and injunctive relief made to a court of appropriate jurisdiction.

6.12 **Notice.**

a. **Delivery.** All notices required or permitted by this Agreement, except for Supplemental Materials, will be in writing and delivered: (i) in person; (ii) by U.S. Postal Service ("USPS") registered, certified, or express mail with postage prepaid; (iii) by overnight courier that guarantees next day delivery; (iv) by facsimile transmission; or (v) by email. Notice is deemed given: (i) on the date of personal delivery; (ii) on the second day after the

postmark date for USPS registered, certified, or express mail with postage prepaid; (iii) on the date of delivery shown by overnight courier; or (iv) on the date of transmission for facsimile or email.

b. **Addresses.** The mailing address, email address, and facsimile number set forth under the Signature Page will be the particular Party's information for delivery of notice. Each Party may change its information through written notice in compliance with this section without amending this Agreement. Notice will be sent to the attention of the Authorized Representative.

6.13 **Waiver.** A failure or delay of a Party to exercise or enforce any provision of this Agreement will not be deemed a waiver of any right of that Party. Any waiver must be specific, in writing, and executed by the Parties.

6.14 **Execution in Counterparts and Duplicates.** This Agreement may be executed in counterparts, each of which will be deemed an original, but all of which together will constitute one and the same instrument. The Parties agree facsimile signatures, pdf signatures, photocopied signatures, electronic signatures, or signatures scanned and sent via email will have the same effect as original signatures.

6.15 **Conflict with Health Plan Product.** Nothing in this Agreement modifies any benefits, terms, or conditions contained in the Member's Product. In the event of a conflict between this Agreement and any benefits, terms, or conditions of a Product, the benefits, terms, and conditions contained in the Member's Product will govern.

6.16 **Force Majeure.** Neither Party will 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 a public enemy, war, accident, fire, explosion, earthquake, flood, strikes by either Party's employees, or any other similar cause beyond the reasonable control of such Party.

6.17 **Confidentiality.** Any information disclosed by either Party in fulfillment of its obligations under this Agreement, including, but not limited to, health care information, compensation rates, and the terms of the Agreement, will be kept confidential. Information provided to Provider, including, but not limited to, Member lists, QI Program, credentialing criteria, compensation rates, and any other administrative protocols or procedures of Health Plan, is the proprietary property of Health Plan and will be kept confidential. Provider will not disclose or release such material to a third party without the written consent of Health Plan. This section will survive any termination.

ATTACHMENT A

Products

Provider's participation in each Product listed below is contingent upon the Product being offered by the appropriate governmental agency and upon Health Plan executing a Government Contract with the appropriate governmental agency. Provider agrees to automatically participate for each Product on the date it becomes operational for Health Plan under its Government Contract and Provider shall be bound to the terms of this Agreement. Providers can opt-out of individual products by providing MPCN with written notice.

1.8 **Medicaid** – including, but not limited to, MississippiCAN and any other Medicaid programs Health Plan offers in the future.

1.9 **CHIP** ¬ including, but not limited to, SCHIP.

1.10 **Medicare Advantage** – Intentionally left blank.

1.11 **Medicare-Medicaid Program.** Intentionally left blank.

1.12 **Health Insurance Marketplace** – including, but not limited to, Molina Marketplace.

ATTACHMENT B

Compensation Schedule

1.1 **Compensation for Medicaid.** Health Plan agrees to compensate Provider on a fee-for-service basis for Covered Services provided under the Medicaid Product, that are determined by Health Plan to be payable and submitted on a Clean Claim, less any applicable amounts paid or to be paid by other liable third parties, if any, at the lesser of the following amounts in effect on the Date of Service: (i) Provider's billed charges; or (ii) an amount equivalent to the Medicaid Fee-For-Service Program allowable payment rate set forth by the State of Mississippi. In the event that there is a code in the State of Mississippi Medicaid Fee-For-Service Program fee schedule as of the Date of Service, but there is no payment rate, Covered Services determined by Health Plan to be payable and submitted on a Clean Claim will be paid on a fee-for-service basis, less any applicable amounts paid or to be paid by other liable third parties, if any, at an amount equivalent to the Medicare Fee-For-Service Program allowable payment rate set forth by CMS (adjusted for locality or geography), as of the Date of Service. The Medicare Fee-For-Service Program allowable payment rate deducts any cost sharing amounts, including, but not limited to, co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties that would have been deducted if the Member were enrolled in the Medicare Fee-For-Service Program.

1.2 **Compensation for CHIP.** Health Plan agrees to compensate Provider on a fee-for-service basis for Covered Services provided under the CHIP Product, that are determined by Health Plan to be payable and submitted on a Clean Claim, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any, at the lesser of the following amounts in effect on the Date of Service: (i) Provider's billed charges; or (ii) an amount equivalent to One Hundred Ten Percent (110%) of the Medicaid Fee-For-Service Program allowable payment rate set forth by the State of Mississippi. In the event that there is a code in the State of Mississippi Medicaid Fee-For-Service Program fee schedule as of the Date of Service, but there is no payment rate, Covered Services determined by Health Plan to be payable and submitted on a Clean Claim will be paid on a fee-for-service basis, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any, at an amount equivalent to the Medicare Fee-For-Service Program allowable payment rate set forth by CMS (adjusted for locality or geography), as of the Date of Service. The Medicare Fee-For-Service Program allowable payment rate deducts any cost sharing amounts, including, but not limited to, co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties that would have been deducted if the Member were enrolled in the Medicare Fee-For-Service Program.

1.3 **Compensation for Medicare Advantage.** Intentionally left blank.

1.4 **Compensation for Medicare-Medicaid Program.** Intentionally left blank.

1.5 **Compensation for Health Insurance Marketplace.** Health Plan agrees to compensate Provider on a fee-for-service basis for Covered Services provided under the Health Insurance Marketplace Product, that are determined by Health Plan to be payable and submitted on a Clean Claim, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any, at the lesser of the following amounts in effect on the Date of Service: (i) Provider's billed charges; or (ii) at an amount equivalent to One Hundred Ten Percent (110%) of the Medicare Fee-For-Service Program allowable payment rates. The Medicare Fee-For-Service Program allowable payment rate deducts any cost sharing amounts, including, but not limited to, co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties that would have been deducted if the Member were enrolled in the Medicare Fee-For-Service Program. Notwithstanding the above, unless prohibited by Law, Provider agrees that in the event there is a retroactive change to the Medicare Fee-For-Service Program allowable payment rate, Health Plan shall have sole discretion to determine if claims will be reprocessed when payment has already been issued to Provider.

In the event that there is no payment rate under the Medicare Fee-For-Service Program allowable payment rate, Covered Services determined by Health Plan to be payable and submitted on a Clean Claim will be paid on a fee-for-service basis, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any, at the lesser of the following amounts in effect on the Date of Service: (i) Provider's billed charges; or (ii) an amount equivalent to the Medicaid Fee-For-Service Program allowable payment rate set forth by the State of Mississippi. Notwithstanding the above, unless prohibited by Law, Provider agrees that in the event there is a retroactive change to the Medicaid Fee-For-Service Program allowable payment rate, Health

Plan shall have sole discretion to determine if claims will be reprocessed when payment has already been issued to Provider.

1.6 **Compensation for Medicaid - RHC Rural Health Clinic (RHC) Covered Services.** Rural Health Clinic (RHC) Covered Services will be paid at an amount equivalent to one hundred percent (100%) of the Mississippi Division of Medicaid Rural Health Clinics (RHC) Prospective Payment System (PPS) fee schedule. Detailed Healthcare Common Procedure Coding System (HCPCS) coding with the associated line item charges listing the visit that qualifies the service for an encounter-based payment and all other RHC services furnished during the encounter are required for payment. Provider will provide Health Plan with its updated Mississippi Division of Medicaid RHC PPS rate within thirty (30) days of receipt and in accordance with the Notice Section of this Agreement. Retroactive changes to the applicable Medicaid RHC fee schedule allowable payment rate, as mandated by the Mississippi Division of Medicaid, will be reprocessed, regardless of net effect to Health Plan or Provider rates.

1.7 **Compensation for CHIP - RHC Rural Health Clinic (RHC) Covered Services.** Rural Health Clinic (RHC) Covered Services will be paid at an amount equivalent to one hundred percent (100%) of the Mississippi Division of Medicaid Rural Health Clinics (RHC) Prospective Payment System (PPS) fee schedule. Detailed Healthcare Common Procedure Coding System (HCPCS) coding with the associated line item charges listing the visit that qualifies the service for an encounter-based payment and all other RHC services furnished during the encounter are required for payment. Provider will provide Health Plan with its updated Mississippi Division of Medicaid RHC PPS rate within thirty (30) days of receipt and in accordance with the Notice Section of this Agreement. Retroactive changes to the applicable Medicaid RHC fee schedule allowable payment rate, as mandated by the Mississippi Division of Medicaid, will be reprocessed, regardless of net effect to Health Plan or Provider rates.

ATTACHMENT C

State of Mississippi Required Provisions

State Laws

This attachment sets forth applicable State Laws or other provisions necessary to reflect compliance with State Laws. This attachment will be automatically modified to conform to subsequent changes to Law. All provisions of the Agreement not specifically modified by this attachment remain unchanged and will control. In the event of a conflict between this attachment and any other provision in the Agreement, the provisions in this attachment will control. Capitalized terms used in this attachment will have the same meaning ascribed to them in the Agreement unless otherwise set forth in this attachment. Any purported modification or any provision in this attachment that is inconsistent with Law will not be effective and will be interpreted in a manner that is consistent with the applicable Law. For the avoidance of doubt, this attachment does not apply to the Medicare Advantage Product or the Medicare-Medicaid Product to the extent such Products are preempted by Federal Law.

1.1 **Definitions.**

a. **Intermediary** means a person authorized to negotiate and execute provider contracts with health carriers on behalf of health care providers or on behalf of a network.

1.2 **Hold Harmless.**

a. Provider agrees that in no event, including, but not limited to, nonpayment by Health Plan or Intermediary, insolvency of the Health Plan or Intermediary, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Member or a person (other than the Health Plan or Intermediary) acting on behalf of Member for Covered Services provided pursuant to this Agreement. This Agreement does not prohibit Provider from collecting coinsurance, deductibles or copayments, as specifically provided in the evidence of coverage, or fees for non-Covered Services delivered on a fee-for-service basis to Member. Nor does this Agreement prohibit a Provider (except for a health care professional who is employed full-time on the staff of a Health Plan and has agreed to provide services exclusively to that Health Plan's Member and no others) and a Member from agreeing to continue services solely at the expense of Member, as long as Provider has clearly informed Member that Health Plan may not cover or continue to cover a specific service or services. Except as provided herein, this Agreement does not prohibit Provider from pursuing any available legal remedy.

b. In the event of a Health Plan or Intermediary insolvency or other cessation of operations, Covered Services to Members will continue through the period for which a premium has been paid to the Health Plan on behalf of the Member or until the Member's discharge from an inpatient facility, whichever time is greater. Covered Service to Members confined in an inpatient facility on the date of insolvency or other cessation of operations will continue until their continued confinement in an inpatient facility is no longer Medically Necessary.

c. Sections 1.2 a and b shall be construed in favor of Members, shall survive the termination of the Agreement regardless of the reason for termination, including the insolvency of Health Plan, and shall supersede any oral or written contrary Agreement between Provider and Member or the representative of Member if the contrary agreement is inconsistent with the hold harmless and continuation of Covered Services provisions required by Sections 1.2 a and b.

d. In no event shall Provider collect or attempt to collect from a Member any money owed to Provider by Health Plan.

1.3 **Provider Protection.**

a. Health Plan shall not prohibit Provider from discussing treatment options with Members irrespective of the Health Plan's position on the treatment options, or from advocating on behalf of Members within the utilization review or grievance processes established by Health Plan or a person contracting with Health Plan.

1.4 **Program Participation.**

a. Provider will comply with Health Plan's applicable administrative policies and programs, including but not limited to terms, including payment, utilization review, quality assessment and improvement programs, credentialing, grievance procedures, data reporting requirements, confidentiality requirements and any applicable federal or state programs.

b. Provider will collect applicable coinsurance, copayments or deductibles from Members, if any, pursuant to the evidence of coverage, or of the Providers' obligations, if any, to notify Members of their personal financial obligations for non-Covered Services.

c. Provider will make health records available to appropriate state and federal authorities involved in assessing the quality of care or investigating the grievances or complaints of Members, and will comply with the applicable state and federal laws related to the confidentiality of medical or health records.

1.5 **General.**

a. The Parties shall provide at least sixty (60) days written notice to each other before terminating the Agreement without cause. Health Plan shall make a good faith effort to provide written notice of a termination within thirty (30) days of receipt or issuance of a notice of termination to all Members who are patients seen on a regular basis by the Provider whose Agreement is terminating, irrespective of whether the termination was for cause or without cause. Where a contract termination involves a primary care professional, all Members who are patients of that primary care professional shall also be notified. Within five (5) working days of the date that the Provider either gives or receives notice of termination, Provider shall supply Health Plan with a list of those Members of the Provider.

b. The rights and responsibilities under this Agreement shall not be assigned or delegated by Provider without the prior written consent of Health Plan.

c. Provider will furnish Covered Services to all Members without regard to the Member's enrollment in the plan as a private purchaser of the plan or as a participant in publicly financed programs of health care services. This requirement does not apply to circumstances when Provider should not render services due to limitations arising from lack of training, experience, skill or licensing restrictions.

d. In the event a definition or other provision of this Agreement conflicts with the definitions or provisions contained in the Managed Care Plan, as defined by Miss. Code Ann. § 83-41-403(b), or Managed Care Plan Network Adequacy Regulation ("Regulation"), Miss. Admin. Code. 19-3:14, et seq., then the definitions or provisions of the Managed Care Plan or Regulation will control.

1.6 **Intermediaries.** The following provisions apply to Intermediaries.

a. Intermediaries and participating providers with whom they contract shall comply with all the applicable requirements of Miss. Admin. Code. 19-3:14.06.

b. Health Plan's statutory responsibility to monitor the offering of Covered Service to Members shall not be delegated or assigned to an Intermediary.

c. Health Plan shall have the right to approve or disapprove participation status of a subcontracted provider in its own or a contracted network for the purpose of delivering Covered Services to Members.

d. Intermediary will ensure that Health Plan has access to all Intermediary subcontracts, including the right to make copies to facilitate regulatory review, upon twenty (20) days prior written notice from Health Plan.

e. If applicable, an Intermediary shall transmit utilization documentation and claims paid documentation to Health Plan. Health Plan shall monitor the timeliness and appropriateness of payments made to Providers and health care services received by Members.

f. If applicable, an Intermediary shall maintain the books, records, financial information and documentation of services provided to Members at its principal place of business in the state and preserve them in a manner that facilitates regulatory review.

g. Intermediary shall allow the commissioner access to Intermediary's books, records, financial information and any documentation of services provided to Members, as necessary to determine compliance with this Regulation.

h. Health Plan shall have the right, in the event of Intermediary's insolvency, to require the assignment to Health Plan of the provisions of a provider's contract addressing the provider's obligation to furnish Covered Services.

ATTACHMENT D

Medicaid

Laws and Government Program Requirements

This attachment sets forth applicable Laws and Government Program Requirements, or other provisions necessary to reflect compliance for the Medicaid Product. This attachment will be automatically modified to conform to subsequent changes to Laws or Government Program Requirements. All provisions of the Agreement not specifically modified by this attachment remain unchanged and will control. In the event of a conflict between this attachment and any other provision in the Agreement, the provisions in this attachment will control for the Medicaid Product. Capitalized terms used in this attachment will have the same meaning ascribed to them in the Agreement unless otherwise set forth in this attachment. Any purported modification or any provision in this attachment that is inconsistent with a Law or Government Program Requirement will not be effective and will be interpreted in a manner that is consistent with the applicable Law and Government Program Requirement. This attachment only applies to Medicaid Product.

1.1 **Right to Audit.** Pursuant to the requirements of Title XIX, Section 1902(a)(27) of the Social Security Act, 42 C.F.R. § 434.6(a)(5) and 42 C.F.R. § 438.3(h), Section 1128A [42 U.S.C. 1320a-7a] and Miss. Code Ann. § 43-13-118,121,229 (1972, as amended), Providers shall make all of its books, documents, papers, Provider records, medical records, financial records, data, surveys and computer databases (collectively referred to as records) available for examination and audit by the Division of Medicaid, Office of the Governor, State of Mississippi ("Division"), the State Attorney General, authorized Federal or State personnel or the authorized representatives of these parties including, without limitation, any employee, agent, or contractor of the Division, CMS, and the Division's Agent. Access will be at the discretion of the requesting authority and will be either through onsite review of records or by submission of records to the office of the requester. Any records requested shall be produced immediately for onsite reviews or sent to the requesting authority by mail within fourteen (14) calendar days following a request, for desk audits. Requests may be written or verbal. All records shall be provided at the sole cost and expense of the Provider including, without limitation, any costs associated with making excerpts or transcripts, copying, reproducing, shipping and/or mailing of records. The Division shall have unlimited rights to use, disclose, and duplicate, all information and data developed, derived, documented, or furnished by Provider and in any way relating to this Agreement in accordance with applicable State and Federal laws and regulations. The right to audit exists for ten (10) years from the final date of the contract between Health Plan and the Division or from the date of completion of any audit, whichever is later.

1.2 **Hold Harmless.**

a. In the event Health Plan becomes insolvent or unable to pay Provider, Provider agrees that it will not seek compensation for services rendered from the State of Mississippi, its officers, agents, or employees, or the Members or their eligible dependents.

b. Provider will hold Members harmless for: (i) any and all debts of Health Plan if it should become insolvent; (ii) payment for Covered Services if Provider fails to receive payment from Health Plan; (iii) payments that are in excess of the amount that normally would be paid by the Member if the services had been received directly from Provider; and (iv) Provider agrees to honor and be bound by Section 1128B(d)(1) of the Balanced Budget Act of 1997.

1.3 **Provider Protection.**

a. Health Plan will not exclude or terminate a Provider from participation in Health Plan's provider network due to the fact that the Provider has a practice that includes a substantial number of patients with expensive medical conditions.

b. Members are entitled to the full range of Providers' opinions and counsel about the availability of Medically Necessary Services under the provisions of the Agreement, Health Plan will not prohibit Provider from discussing treatment options with Member.

c. Health Plan will not prohibit or restrict a Provider from acting within the lawful scope of practice or from discussing Medically Necessary care and advising or advocating appropriate medical care with or on behalf of a

Member including, information regarding the nature of treatment options; risks of treatment; alternative treatments; or the availability of alternative therapies, consultation or tests that may be self-administered.

d. Health Plan will not prohibit or restrict Provider, acting within the lawful scope of practice, from providing information the Member needs in order to decide among all relevant treatment options and the risks, benefits, and consequences of treatment or non-treatment.

e. Health Plan cannot terminate a contract or employment with a Provider for filing a complaint, grievance, or appeal on a Member's behalf.

f. Health Plan may not enter into an agreement that prohibits the Provider from contracting with another health plan or that prohibits or penalizes Health Plan for contracting with other providers. Health Plan may not require Providers who agree to participate in the MississippiCAN Program to contract with Health Plan's other lines of business.

g. Health Plan will pay at least ninety percent (90%) of all Clean Claims (as defined by Miss. Code Ann. § 83-9-5) for Covered Services, within thirty (30) calendar days of receipt and pay at least ninety-nine percent (99%) of all Clean Claims within ninety (90) calendar days of receipt, except to the extent an alternative payment schedule has been agreed to by the Parties.

1.4 **Program Participation.**

a. Provider agrees to comply with the requirements specified in 42 C.F.R. § 438.214 and Miss. Code Ann. § 83.41.409 (e).

b. Provider agrees to cooperate with Quality Management and Utilization Management Program standards outlined in Section 10, Quality Management, of the contract between Health Plan and the Division of Medicaid, Office of the Governor, State of Mississippi ("State Contract").

c. Primary Care Providers ("PCPs") agree to comply with requirements of Section 7.C, PCP Responsibilities, of the State Contract.

d. Provider agrees to comply with all applicable laws and regulations pertaining to the confidentiality of Member medical records, including obtaining any required written Member consents to disclose confidential medical records.

e. Provider must make referrals for social, vocational, education, or human services when a need for such service is identified.

f. Provider shall ensure the maintenance of current, detailed, organized medical records for each Member sufficient to disclose the quality, quantity, appropriateness, and timeliness of services performed pursuant to this Agreement. As described in 42 C.F.R. Part 456, Subparts C and D, medical record content must include, at a minimum for hospitals and mental hospitals: (i) identification of Member; (ii) physician name; (iii) date of admission and dates of application for, and authorization of, Medicaid benefits if application is made after admission; the plan of care; (iv) initial and subsequent continued stay review dates; (v) reasons and plan for continued stay if applicable; (vi)other supporting material the committee believes appropriate to include; (vii) for non-mental hospitals only, date of operating room reservation; and (viii) for non-mental hospitals only, justification of emergency admission if applicable.

g. Provider agrees to submit Claims within one hundred eighty (180) calendar days from the Date of Service. Claims filed within the appropriate time frame but denied may be resubmitted to Health Plan within ninety (90) calendar days from the date of denial.

h. Medical records shall be accessible and made available by Providers and to the Division for purposes of medical record review.

i. Providers will provide physical access, reasonable accommodations, and accessible equipment for Members with physical or mental disabilities.

j. Provider must ensure that all Members receiving inpatient and Psychiatric Residential Treatment Facility ("PRTF") services are provided with a transitional care plan that includes outpatient follow-up and/or continuing treatment prior to discharge from the inpatient setting or PRTF.

k. Providers must be enrolled in the Mississippi Medicaid program using the same National Provider Identifier ("NPI") numbers and Mississippi Medicaid Provider Numbers with active enrollment segments. Additionally, Providers must be enrolled as group or individual providers consistent with enrollment with the Division. Nurse practitioners acting as PCPs shall be held to the same requirements and standards as physicians acting at PCPs.

1.5 **General.**

a. In the event Provider is reimbursed on a capitation basis by Health Plan and this Agreement terminates for any reason, Provider will provide services to Members assigned to Provider under this Agreement up to the end of the month in which the effective date of termination falls.

b. Health Plan may deny or revoke the Agreement, for cause, for any reasons set forth in 42 C.F.R. §§ 455.416, 455.420, 1001.1001 and Miss. Code Ann. § 43-13-121(7).

c. Health Plan will not reimburse Provider for services rendered by any provider that is excluded or debarred from participation by Medicare, Medicaid, including any other states' Medicaid program, or CHIP, including any other states' or CHIP program, except for emergency services.

d. Health Plan will be responsible for the administration and management of all aspects of Health Plan and the performance of all of the covenants, conditions and obligations imposed upon Health Plan pursuant to this State Contract. No delegation of responsibility, whether by subcontract or otherwise, shall terminate or limit in any way the liability of Health Plan to the Division for the full performance of the State Contract.

ATTACHMENT D-1

CHIP

Laws and Government Program Requirements

This attachment sets forth applicable Laws and Government Program Requirements, or other provisions necessary to reflect compliance for the CHIP Product. This attachment will be automatically modified to conform to subsequent changes to Laws or Government Program Requirements. All provisions of the Agreement not specifically modified by this attachment remain unchanged and will control. In the event of a conflict between this attachment and any other provision in the Agreement, the provisions in this attachment will control for the CHIP Product. Capitalized terms used in this attachment will have the same meaning ascribed to them in the Agreement unless otherwise set forth in this attachment. Any purported modification or any provision in this attachment that is inconsistent with a Law or Government Program Requirement will not be effective and will be interpreted in a manner that is consistent with the applicable Law and Government Program Requirement. This attachment only applies to the CHIP Product.

1.1 **Right to Audit.** Pursuant to the requirements of Title XXI, Section 2107(b)(3) of the Social Security Act, 42 C.F.R.§ 434.6(a)(5), § 457.720, and § 457.950, Provider shall make all of its books, documents, papers, Provider records, medical records, financial records, data, surveys and computer databases (collectively referred to as records) available for examination and audit by the Division of Medicaid, Office of the Governor, State of Mississippi ("Division"), the State Attorney General, authorized Federal or State personnel or the authorized representatives of these parties including, without limitation, any employee, agent, or contractor of the Division, CMS, and the Division's Agent. Access will be at the discretion of the requesting authority and will be either through onsite review of records or by submission of records to the office of the requester. Any records requested shall be produced immediately for onsite reviews or sent to the requesting authority by mail within fourteen (14) calendar days following a request, for desk audits. Requests may be written or verbal. All records shall be provided at the sole cost and expense of the Provider including, without limitation, any costs associated with making excerpts or transcripts, copying, reproducing, shipping and/or mailing of records. The Division shall have unlimited rights to use, disclose, and duplicate, all information and data developed, derived, documented, or furnished by Provider and in any way relating to this Agreement in accordance with applicable State and Federal laws and regulations. There will be no restrictions on the right of the State or Federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness, or timeliness of services and reasonableness of their costs.

1.2 **Hold Harmless.**

a. In the event Health Plan becomes insolvent or unable to pay Provider, Provider agrees that it will not seek compensation for services rendered from the State of Mississippi, its officers, agents, or employees, or the Members or their eligible dependents.

b. Provider will hold Members harmless for: (i) any and all debts of Health Plan if it should become insolvent; (ii) payment for Covered Services if Provider fails to receive payment from Health Plan; (iii) payments that are in excess of the amount that normally would be paid by the Member if the services had been received directly from Provider; and (iv) Provider agrees to honor and be bound by Section 1128B (d)(1) of the Balanced Budget Act of 1997.

1.3 **Provider Protection.**

a. Health Plan will not exclude or terminate a Provider from participation in Health Plan's provider network due to the fact that the Provider has a practice that includes a substantial number of patients with expensive medical conditions.

b. Members are entitled to the full range of Providers' opinions and counsel about the availability of Medically Necessary Services under the provisions of the Agreement, Health Plan will not prohibit Provider from discussing treatment options with Member.

c. Health Plan will not prohibit or restrict a Provider from acting within the lawful scope of practice or from discussing Medically Necessary care and advising or advocating appropriate medical care with or on behalf of a

Member including, information regarding the nature of treatment options; risks of treatment; alternative treatments; or the availability of alternative therapies, consultation or tests that may be self-administered.

d. Health Plan will not prohibit or restrict Provider, acting within the lawful scope of practice, from providing information the Member needs in order to decide among all relevant treatment options and the risks, benefits, and consequences of treatment or non-treatment.

e. Health Plan cannot terminate a contract or employment with a Provider for filing a complaint, grievance, or appeal on a Member's behalf.

f. Health Plan may not enter into an agreement that prohibits the Provider from contracting with another health plan or that prohibits or penalizes Health Plan for contracting with other providers. Health Plan may not require Providers who agree to participate in the CHIP Program to contract with Health Plan's other lines of business.

g. Health Plan will pay at least ninety percent (90%) of all Clean Claims (as defined by Miss. Code Ann. § 83-9-5) for Covered Services, within thirty (30) calendar days of receipt and pay at least ninety-nine percent (99%) of all Clean Claims within ninety (90) calendar days of receipt, except to the extent an alternative payment schedule has been agreed to by the Parties.

1.4 **Program Participation.**

a. Provider agrees to comply with the requirements specified in 42 C.F.R. § 438.214 and Miss. Code Ann. § 83.41.409 (e).

b. Provider agrees to cooperate with Quality Management and Utilization Management Program standards outlined in Section 9, Quality Management, of the contract between Health Plan and the Division of Medicaid, Office of the Governor, State of Mississippi ("State Contract").

c. Primary Care Providers ("PCPs") agree to comply with requirements of Section 7.C, PCP Responsibilities, of the State Contract.

d. Provider agrees to comply with all applicable laws and regulations pertaining to the confidentiality of Member medical records, including obtaining any required written Member consents to disclose confidential medical records.

e. Provider must make referrals for social, vocational, education, or human services when a need for such service is identified.

f. Provider shall ensure the maintenance of current, detailed, organized medical records for each Member sufficient to disclose the quality, quantity, appropriateness, and timeliness of services performed pursuant to this Agreement. As described in 42 C.F.R. Part 456, Subparts C and D, medical record content must include, at a minimum for hospitals and mental hospitals: (i) identification of Member; (ii) physician name; (iii) date of admission and dates of application for, and authorization of, Medicaid benefits if application is made after admission; the plan of care; (iv) initial and subsequent continued stay review dates; (v) reasons and plan for continued stay if applicable; (vi)other supporting material the committee believes appropriate to include; (vii) for non-mental hospitals only, date of operating room reservation; and (viii) for non-mental hospitals only, justification of emergency admission if applicable.

g. Provider agrees to submit Claims within one hundred eighty (180) calendar days from the Date of Service. Claims filed within the appropriate time frame but denied may be resubmitted to Health Plan within ninety (90) calendar days from the date of denial.

h. Medical records shall be accessible and made available by Providers and to the Division for purposes of medical record review.

i. Providers will provide physical access, reasonable accommodations, and accessible equipment for Members with physical or mental disabilities.

j. Provider must ensure that all Members receiving inpatient and Psychiatric Residential Treatment Facility ("PRTF") services are provided with a transitional care plan that includes outpatient follow-up and/or continuing treatment prior to discharge from the inpatient setting or PRTF.

k. Health Plan may execute agreements pending the outcome of the process in 42 C.F.R.§438.602 (b)(1) for up to one hundred and twenty (120) days, but Health Plan must terminate Provider immediately upon notification from the State that Provider cannot be enrolled, or the expiration of one (1) one hundred and twenty (120) day period without enrollment of Provider.

1.5 **General.**

a. In the event Provider is reimbursed on a capitation basis by Health Plan and this Agreement terminates for any reason, Provider will provide services to Members assigned to Provider under this Agreement up to the end of the month in which the effective date of termination falls.

b. Health Plan may deny or revoke the Agreement, for cause, for any reasons set forth in 42 C.F.R. §§ 455.416, 455.420, 1001.1001 and Miss. Code Ann. § 43-13-121 (7).

c. Health Plan will not reimburse Provider for services rendered by any provider that is excluded or debarred from participation by Medicare, Medicaid, including any other states' Medicaid program, or CHIP, including any other states' or CHIP program, except for emergency services.

d. Health Plan will be responsible for the administration and management of all aspects of Health Plan and the performance of all of the covenants, conditions and obligations imposed upon Health Plan pursuant to this State Contract. No delegation of responsibility, whether by subcontract or otherwise, shall terminate or limit in any way the liability of Health Plan to the Division for the full performance of the State Contract.

ATTACHMENT E

Medicare Advantage

Laws and Government Program Requirements

This attachment sets forth applicable Laws and Government Program Requirements, or other provisions necessary to reflect compliance for the Medicare Advantage Product. This attachment will be automatically modified to conform to subsequent changes to Laws or Government Program Requirements. All provisions of the Agreement not specifically modified by this attachment remain unchanged and will control. In the event of a conflict between this attachment and any other provision in the Agreement, the provisions in this attachment will control for the Medicare Advantage Product. Capitalized terms used in this attachment will have the same meaning ascribed to them in the Agreement unless otherwise set forth in this attachment. Any purported modification or any provision in this attachment that is inconsistent with a Law or Government Program Requirement will not be effective and will be interpreted in a manner that is consistent with the applicable Law and Government Program Requirement. This attachment only applies to Medicare Advantage Product.

Placeholder – To be populated at a later date.

ATTACHMENT F

Medicare-Medicaid Program

Laws and Government Program Requirements

This attachment sets forth applicable Laws and Government Program Requirements, or other provisions necessary to reflect compliance for the MMP Product. This attachment will be automatically modified to conform to subsequent changes to Laws or Government Program Requirements. All provisions of the Agreement not specifically modified by this attachment remain unchanged and will control. In the event of a conflict between this attachment and any other provision in the Agreement, the provisions in this attachment will control for the MMP Product. Capitalized terms used in this attachment will have the same meaning ascribed to them in the Agreement unless otherwise set forth in this attachment. Any purported modification or any provision in this attachment that is inconsistent with a Law or Government Program Requirement will not be effective and will be interpreted in a manner that is consistent with the applicable Law and Government Program Requirement. This attachment only applies to MMP Product.

Placeholder – To be populated at a later date.

ATTACHMENT G

Molina Marketplace

Laws and Government Program Requirements

This attachment sets forth applicable Laws and Government Program Requirements or other provisions necessary to reflect compliance for the Molina Marketplace Product. This attachment will be automatically modified to conform to subsequent changes to Laws or Government Program Requirements. All provisions of the Agreement not specifically modified by this attachment remain unchanged and will control. In the event of a conflict between this attachment and any other provision in the Agreement, the provisions in this attachment will control for the Molina Marketplace Product. Capitalized terms used in this attachment will have the same meaning ascribed to them in the Agreement unless otherwise set forth in this attachment. Any purported modification or any provision in this attachment that is inconsistent with a Law or Government Program Requirement will not be effective and will be interpreted in a manner that is consistent with the applicable Law and Government Program Requirement. This attachment only applies to Molina Marketplace Product.

1.1 **Definitions.** The following definitions apply only in this attachment:

a. **Delegated Entity** means any party that enters into an agreement with a qualified health plan ("QHP") issuer to provide administrative services or health care services to qualified individuals and their dependents.

b. **Downstream Entity** means any party that enters into an agreement with a Delegated Entity or with another downstream entity for purposes of providing administrative or health care services related to the agreement between the Delegated Entity and the QHP issuer. The term is intended to reach the entity that directly provides administrative services or health care services to qualified individuals and their dependents.

c. Consistent with the above definitions, Provider is a Delegated Entity and Health Plan is a QHP issuer.

1.2 **Timely Payment of Claims.** Health Plan will pay Provider for Clean Claims for Covered Services that are determined to be payable, in accordance with the pertinent provisions of Miss. Code Ann. § 83-9-5, et seq.

1.3 **Delegated Entity and Downstream Entity Compliance.** To the extent that the activities and obligations applicable to Health Plan, as set forth in the standards enumerated at 45 CFR 156.340(a), are delegated to Provider, then Provider, as Delegated Entity, agrees to perform such activities and obligations in compliance with all applicable laws and regulations relating to such standards, and consistent with the requirements outlined in this attachment. Provider further agrees that it will require the same of any Downstream Entities. (45 CFR 156.340(b)(3)).

1.4 **Health Plan Accountability.** Notwithstanding any relationship Health Plan may have with Provider, as Delegated Entity, and any Downstream Entity, Health Plan maintains responsibility for its compliance, as well as the compliance of the Provider and any Downstream Entity, with all applicable standards enumerated at 45 CFR 156.340(a). (45 CFR 156.340(a)).

1.5 **Delegated Activities and Reporting Arrangements.** The Agreement specifies the delegated activities and reporting responsibilities. (45 CFR 156.340(b)(1)).

1.6 **Right to Audit.** Provider, as Delegated Entity, and any Downstream Entity shall permit access to the Secretary of the United States Department of Health and Human Services ("HHS"), and the Office of the Inspector General, or their designees, to evaluate through audit, inspection, or other means, Provider's or Downstream Entity's books, contracts, computers, or other electronic systems, including medical records and documentation, relating to Health Plan's obligations in accordance with the standards enumerated at 45 CFR 156.340(a), as applicable, until ten (10) years from the final date of the Agreement period. (45 CFR 156.340(b)(4)).

1.7 **Revocation of Delegated Activities.** In the event HHS or Health Plan determines, in its sole discretion, that Provider or any Downstream Entity, have not performed the delegated activities and reporting obligations satisfactorily, consistent with applicable standards enumerated at 45 CFR 156.340(a), then the delegated activities and reporting obligations shall be revoked. The foregoing does not preclude the employment of other remedies, in lieu of revocation of the delegated activities or reporting responsibilities, if deemed appropriate by HHS or Health Plan, as applicable. (45 CFR 156.340(b)(2)).

MAGNOLIA HEALTH PLAN/MISSISSIPPICAN
AMENDMENT TO MISSISSIPPI PHYSICIANS CARE NETWORK
PHYSICIAN SERVICE AGREEMENT

This Amendment ("Amendment") is entered into as of _____ by Mississippi Physicians Care Network, Inc. ("MPCN") and _____ ("Participating Physician"), collectively referred to herein as the "Parties".

WHEREAS, MPCN and Participating Physician have previously entered into a Mississippi Physicians Care Network Physician Service Agreement (the "Agreement") as of _____ (hereinafter referred to as the "Effective Date");

WHEREAS, in accordance with such Agreement, MPCN has entered into a contract with Magnolia Health Plan ("CCO") so that CCO becomes a Payor, as that term is defined in the Agreement;

WHEREAS, CCO has contracted with the state of Mississippi's Division of Medicaid to arrange for the provision of medical services to Beneficiaries under the Mississippi CAN Program ("CCO Beneficiaries");

WHEREAS, the Parties desire to amend the Agreement to comply with the requirements of both Magnolia Health Plan and the Mississippi CAN Program;

NOW THEREFORE, in consideration of the promises and mutual covenants herein contained, the Parties agree as follows:

1. The attached "Mississippi CAN Product & State Mandated Attachment" and "Attachment A to the Mississippi CAN Product & State Mandated Attachment" shall be incorporated into the Agreement.

2. The following is added to Section 13.5 of the Agreement:

   Notwithstanding the foregoing, in the event that the contract between MPCN and CCO terminates for any reason or MPCN becomes insolvent, MPCN and Participating Physician agree to the partial assignment of the Agreement to CCO such that CCO shall assume those rights and responsibilities as a Payor under the Agreement and Participating Physician's rights and responsibilities under the Agreement pursuant to such partial assignment shall be limited to those rights owed by, and responsibilities due to, CCO as a Payor under the Agreement. In no event shall CCO assume any of MPCN's rights and responsibilities under the Agreement as a result of such partial assignment. MPCN and Participating Physician agree to execute any necessary documents in order to effectuate such partial assignment.

3. An Article XV shall be added to the Agreement as follows:

ARTICLE XV
Magnolia Health Plan and Mississippi CAN Requirements

15.1 **Access to Records**. Participating Physician agrees that CCO has access to medical records, to the extent permitted by state and federal laws.

15.2 **Communication regarding Treatment**. Participating Physician may freely communicate with patients about their treatment, regardless of benefit coverage limitations.

15.2.1 Provision of Services. Participating Physician shall ensure that waiting periods for appointments or waiting periods for services for CCO Beneficiaries once an appointment is made shall comply with Regulatory Requirements. For purposes of this Amendment, "Regulatory Requirements" shall be defined as any applicable rule, regulation, statute or other binding legal guidance or directives issued by a State Agency (which for purposes of this Amendment shall mean the applicable State Medicaid Agency or other applicable governmental agency or division), or federal agency, or any applicable contractual provision in any State Contract (which for purposes of this Amendment shall mean a written agreement entered into between the CCO and an applicable State Agency pursuant to which CCO has agreed to arrange to provide Covered Services to CCO Beneficiaries) or other applicable contract between CCO and a federal government agency. If applicable, Participating Physician shall also ensure that Covered Services provided or arranged for under this Agreement are available on a basis of twenty-four (24) hours a day, seven (7) days a week, as the nature of the CCO Beneficiary's condition dictates.

15.3 **Notice to CCO Beneficiaries of Specialist Termination**. If Participating Physician is a specialist or specialty group practice and this Agreement or Amendment is terminated, Participating Physician shall provide written notice within thirty (30) business days of receipt, or issuance of a notice of termination, to all CCO Beneficiaries who are seen on a regular basis by Participating Physician, regardless of whether the termination was for cause or without cause

15.4 **Compliance with CCO's Provider Manual**. Participating Physician shall at all times cooperate and comply with CCO's Provider Manual.

15.5 **Compliance with CCO's Hold Harmless Provision.** Participating Physician agrees to comply with CCO's hold harmless requirements contained in Section 3.1 of Mississippi CAN Product and State Mandated Attachment (the "Product Attachment").

15.6 **Determination of CCO Beneficiary Eligibility.** Participating Physician shall determine whether a person seeking Covered Services is a CCO Beneficiary. If Participating Physician determines that such person was not eligible for coverage at the time the services were rendered, such services shall not be eligible for payment under this Agreement, and Participating Physician may bill the affected person directly for such services at the applicable rates to the extent permitted by Regulatory Requirements.

15.7 **Notification of Emergency Services**. If applicable, Participating Physician agrees to accommodate CCO Beneficiary emergencies on the same basis that Participating Physician would accommodate emergencies with respect to a person covered under any other plan of benefits, and to provide Medically Necessary Emergency Care to CCO Beneficiaries. Participating Physician shall notify CCO within twenty-four (24) hours or by the next business day of rendering or learning of the rendering of Emergency Care to a CCO Beneficiary.

15.8 **Acceptance of New Patients.** To the extent that any Participating Physician is accepting new patients, such Participating Physician must also accept new patients who are CCO Beneficiaries. In no event shall any established patient of a Participating Physician who becomes a CCO Beneficiary be considered a new patient.

15.9 **Referrals.** Participating Physician providing services upon referral shall, in accordance with the requirements of CCO's Provider Manual, make a report to the CCO Beneficiary's Primary Care Physician (PCP). Participating Physician shall immediately refer all CCO Beneficiaries with known or suspected physical health problems or disorders to their primary care provider for examination and treatment. Participating Physician shall provide only those health care services that fall within the scope of their licenses.

15.10 **Drug Formulary.** Participating Physician shall abide by CCO's drug formulary when prescribing medications for CCO Beneficiaries in accordance with CCO's Provider Manual.

15.11 **Participating Physician Responsibilities.** Each Participating Physician shall establish a provider/patient relationship with each CCO Beneficiary that such individual treats. Each Participating Physician shall at all times maintain control over the diagnosis and treatment of CCO Beneficiary and responsibility for providing services under this Agreement in a manner which: (i) is compatible with accepted professional standards of medical care and medical ethics prevailing in the community; (ii) emphasizes preventative care and health maintenance; and (iii) at all times is rendered to CCO Beneficiaries in a dignified, exemplary, and non-discriminatory manner. CCO shall not be liable for, nor will it exercise control over, the manner or method by which any Participating Physician provides or arranges for Covered Services under this Agreement. CCO's determinations (if any) to deny payments for services which CCO does not deem to constitute Covered Services or which were not provided in accordance with the requirements of this Agreement, the Attachments or CCO's Provider Manual, are administrative decisions only. Notwithstanding any language in this Agreement, any Attachment or CCO's Provider Manual to the contrary, such a denial does not absolve any Participating Physician of his/her responsibility to exercise independent judgment in the provision of care and treatment to CCO Beneficiaries and in no way limits or restricts any Participating Physician's ability to provide or recommend treatment which he/she believes is necessary for the appropriate care and treatment of any patient.

15.11.1 Non-Discrimination. Participating Physician agrees that there shall be no discrimination between or intentional segregation of CCO Beneficiaries by Participating Physician and any other patients of Participating Physician, and that Participating Physicians shall provide Covered Services without regard to race, color, religion, sex, national origin, ancestry, age, physical or mental disability, type of CCO benefit coverage, or Payor, or source of payment.

15.12 **Utilization Management Program.** Participating Physician shall cooperate with, participate in, and abide by the decisions of any utilization review programs established by CCO or the State Agency. Participating Physician acknowledges and agrees that the failure to comply with this section and said programs shall be grounds for denial of payment.

15.13 **Grievance & Appeals Procedures.** Participating Physician shall cooperate with CCO's Beneficiary and Provider grievance and appeals procedures, and Participating Physician shall agree that all communications and documents relating to benefit determinations, complaints, and grievances and records relating to such problems shall be referred to CCO in accordance with the grievance procedures.

15.14 **Written Notice**. Participating Physician shall give written notice to CCO of: (i) any action involving Participating Physician's hospital privileges or conditions relating to Participating Physician's ability to admit patients to any hospital or inpatient facility; (ii) any situation which develops regarding Participating Physician, when notice of that situation has been given to the state agency that licenses Participating Physician, or any other licensing agency or board, or any situation involving an investigation or complaint filed by the state agency that licenses Participating Physician, or any other licensing agency or board, regarding a complaint against Participating Physician's license; (iii) when a change in Participating Physician's license to practice medicine is affected or any form of reportable discipline is taken against such license; (iv) suspension or exclusion under a federal health care program, including but not limited to, Medicaid; (v) any government agency request for access to records; or (vi) any adverse determination in connection with a lawsuit or claim filed or asserted against Participating Physician alleging professional malpractice, regardless of whether the lawsuit or claim involves a CCO Beneficiary. In any such instance described above, Participating Physician must notify CCO in writing within ten (10) days from the date he or she first receives notice, whether written or oral, with the exception of those lawsuits or claims which do not involve a CCO Beneficiary, with respect to which Participating Physician has thirty (30) days to notify CCO.

15.15 **Timely Filing**. CCO shall pay or deny in accordance with the MississippiCAN Contract, as that term is defined in the MississippiCAN Product & State Mandated Attachment. The timeframes for claim payment set forth in the Agreement shall not apply for claims of CCO Beneficiaries.

15.16 **Termination**.

A. Participating Physician's participation with CCO may be terminated immediately upon written notice by CCO if there is imminent harm to patient health or fraud or malfeasance is suspected.

B. Participating Physician's participation may be terminated without cause and at any time upon ninety (90) days prior written notice to Participating Physician.

C. Participating Physician's participation may be terminated without cause and at any time upon ninety (90) days prior written notice to CCO and MPCN.

15.17 **Recoupment**. CCO shall have the right to immediately recoup any and all amounts owed by Participating Physician to CCO against amounts owed by CCO to Participating Physician. Such recoupment by CCO is limited to the twelve (12) months after the payment was initially made except in cases where the overpayment resulted from fraud or abuse by or on behalf of Participating Physician, or when CCO's ability to discover the overpayment during the twelve (12) month period was hindered by Participating Physician's failure to provide full and timely cooperation with an audit by CCO. Participating Physician 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 Participating Physician.

15.18 **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 CCO's Provider Manual, if applicable, 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 by providing written notice to the other party. Either party wishing to pursue such a 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 aforementioned sixty (60) day negotiation period. Arbitrations 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.

4. All other terms and conditions of the Agreement and any amendments thereto, if any, shall remain in full force and effect. If the terms of this Amendment conflict with any of the terms of the Agreement, the terms of this Amendment shall prevail for Covered Services provided to CCO Beneficiaries only. The terms and conditions of this Amendment shall apply only with regard to Covered Services provided to CCO Beneficiaries.

IN WITNESS WHEREOF, the Parties hereto have executed and delivered this Amendment as of the date first set forth above.

MPCN:

By:_____

Name:_____

Title:_____

Date:_____

PARTICIPATING PHYSICIAN:

By:_____

Name:_____

Title:_____

Date:_____

Tax Identification Number:_____

Group NPI _____

Indv. State Medicaid ID: _____

MEDICAID ID REQUIRED FOR ENROLLMENT

ATTACHEMENT A
MISSISSIPPICAN PRODUCT AND STATE MANDATED ATTACHMENT

This MississippiCAN Product and State Mandated Attachment (the "***Product Attachment***") is incorporated into the Mississippi Physicians Care Network Agreement (the "***Agreement***") entered into by and between_____(in this Product Attachment referred to as "***Provider***") and Mississippi Physicians Care Network, Inc. ("***MPCN***").

ARTICLE I
RECITALS

1.1 CCO has contracted with the state of Mississippi's Division of Medicaid ("***Division***") to arrange for the provision of medical services to Covered Persons under the MississippiCAN Program.

1.2 Provider has entered into the Agreement with MPCN. This Product Attachment is intended to supplement the Agreement by setting forth the parties' rights and responsibilities related to the provision of Covered Services to Covered Persons as it pertains to the MississippiCAN Program. 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 Notwithstanding any provisions set forth in this Product Attachment, to the extent applicable, Provider shall comply with all duties and obligations under the Agreement, the Provider Manual and this Product Attachment. Provider agrees and understands that Covered Services shall be provided in accordance with the contract between the Division and CCO (***"MississippiCAN Contract"***), the Provider Manual, any applicable State handbooks or policy and procedure guides, and all applicable State and federal laws and regulations. To the extent Provider is unclear about Provider's duties and obligations, Provider shall request clarification from CCO.

ARTICLE II
DEFINITIONS

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

2.1 ***Action*** means CCO's decision to deny or limit authorization or payment (in whole or in part) for health care services, including new authorizations and previously authorized services; the reduction, suspension, or termination of a previously authorized service; or CCO's failure to provide services in a timely manner; failure to resolve Complaints, Grievances, or Appeals within the time frames specified in this contract.

2.2 ***Agent*** means an authorized entity that acts on behalf of the Division.

2.3 ***Appeal*** means a request for review by the CCO of a CCO Action related to a Covered Person or Provider. In the case of a Covered Person, the CCO Action may include determinations on the health care services a Covered Person believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the Covered Person). In the case of a Provider, the CCC|O Action may include, but is not limited to, delay or non-payment for Covered Services.

2.4 ***Behavioral Health Services*** means mental health and/or drug and alcohol abuse treatment services that are provided by the county mental health/mental retardation programs, the single county authority administrators, or other appropriately licensed health care practitioners.

2.5 ***Complaint*** means an expression of dissatisfaction received orally or in writing that is of a less serious or formal nature that is resolved within one (1) business day of receipt.

2.6 ***Cultural Competency*** or ***Culturally Competent*** means the ability to understand, communicate with, and effectively interact with people across cultures. Cultural competence comprises four components: (i) awareness of one's own cultural worldview; (ii) attitude towards cultural differences; (iii) knowledge of different cultural practices and worldviews; and (iv) cross-cultural skills.

2.7 ***Grievance*** means an expression of dissatisfaction about any matter or aspect of the CCO or its operation, other than a CCO Action.

2.8 ***Medical Necessity*** or ***Medically Necessary*** means services, supplies, or equipment provided by a licensed health care professional that are: (i) appropriate and consistent with the diagnosis or treatment of the patient's condition, illness, or injury; (ii) in accordance with the standards of good medical practice consistent with the individual patient's condition(s); (iii) not primarily for the personal comfort or convenience of the Covered Person, family, or Provider; (iv) the most appropriate services, supplies, equipment, or levels of care that can be safely and efficiently provided to the Covered Person; (v) furnished in a setting appropriate to the patient's medical need and condition and, when applied to the care of an inpatient, further mean that the Covered Person's medical symptoms or conditions require that the services cannot be safely provided to the Covered Person as an outpatient; (vi) not experimental or investigational or for research or education; (vii) are provided by an appropriately licensed practitioner; and (viii) are documented in the patient's record in a reasonable manner, including the relationship of the diagnosis to the service.

2.9 ***Medical Record*** means a single complete record, which documents the entire treatment plan developed for, and medical services received by, the Covered Person including inpatient, outpatient, referral services and emergency medical services.

2.10 ***Member(s)*** or ***Covered Person(s)*** means Medicaid beneficiaries who have enrolled with CCO in the MississippiCAN Program.

2.11 ***MississippiCAN Program*** means the State's Medicaid coordinated care program for the following Medicaid eligibility category: select targeted, high cost Medicaid beneficiaries.

2.12 ***Never Event*** means an adverse event that is serious, largely preventable, and of concern to both the public and Provider for the purpose of public accountability as defined by the National Coverage Determinations (NCD). The Never Events as defined in the NCD include ambulatory surgical centers (ASC) and practitioners.

2.13 ***Non-Contracted Provider*** means a health care provider who has not been credentialed by and does not have a signed provider agreement with the CCO.

2.14 ***Panel*** means a listing and number of Covered Persons that Provider has agreed to provide services for in accordance with the MississipiCAN Contract.

2.15 ***Provider Network*** means the Panel of health service providers with which CCO contracts for the provision of Covered Services to Covered Persons and Non-Contracted Providers administering services to Covered Persons.

2.16 ***State Plan*** means the Mississippi State Plan for Medical Assistance in accordance with the requirements of Title XIX of the Social Security Act of 1935, as amended, (the "Act") and Miss. Code Ann. §43-13-101 et. seq. (1972, as amended).

ARTICLE III
PRODUCT REQUIREMENTS

3.1 **Hold Harmless.** Provider agrees to not hold Covered Persons liable for: (a) any and all debts of CCO if CCO should become insolvent; (b) payment for services provided by the CCO if the CCO has not received payment from the State for the services, or if Provider, under contract or other arrangement with CCO, fails to receive payment from the State or CCO; or (c) to the extent applicable, the payments to Provider for furnishing Covered Services that are in excess of the amount that normally would be paid by the Covered Person if CCO authorized or provided the services directly.

3.2 **Cultural Competency.** Provider must ensure that cultural differences between the Provider and Covered Persons do not present barriers to access and quality health care. Provider must be able to demonstrate the ability to provide quality health care across a variety of cultures.

3.3 **Access to Records.** Provider shall maintain current, detailed, organized Medical Records for each Covered Person sufficient to disclose the quality, quantity, appropriateness and timeliness of services performed pursuant to the Agreement and/or the MississippiCAN Contract. Provider shall make such Medical Records accessible and available to providers providing services to Covered Persons, and to the Division for purposes of Medical Record review. Provider shall make all of its books, documents, papers, provider records, Medical Records, financial records, data, surveys and computer databases (collectively

referred to as "records") available for examination and audit by the Division, the State Attorney General, authorized federal or State personnel or the authorized representatives of these parties including, without limitation, any employee, agent, or contractor of the Division, the Centers for Medicare and Medicaid Services ("CMS"), and the Division's Agent. Access will be at the discretion of the requesting authority and will be either through on-site review of records or by submission of records to the office of the requester. Any records requested hereunder shall be produced immediately for on-site reviews or sent to the requesting authority by mail within fourteen (14) calendar days following a request, for desk audits. Requests may be written or verbal. Provider shall maintain and make records available for review by authorized federal and State agencies during the term of the Agreement and for a minimum period of five (5) years thereafter, unless an audit is in progress. When an audit is in progress or audit findings are unresolved, Provider shall maintain records for a period of five (5) years or until all issues are finally resolved, whichever is later.

The Division shall have unlimited rights to use, disclose, and duplicate, all information and data developed, derived, documented, or furnished by Provider hereunder in accordance with applicable State and Federal laws and regulations.

Any person (including an organization, agency or other entity, but excluding a Covered Person) that fails to grant timely access, upon reasonable request (as defined by the Secretary in regulations), to the Inspector General of the Department of Health and Human Services, for the purpose of audits, investigations, evaluations or other statutory functions of the Inspector General of the Department of Health and Human Services, the Division, or any other duly authorized representative, shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of $15,000 for each day of the failure to make accessible all books, documents, papers, Provider records, Medical Records, financial records, data, surveys and computer databases (collectively referred to as records). In addition, the Division may make a determination to terminate the contract.

3.4 **Access Standards.** Provider shall provide Covered Services to Covered Persons in accordance with the following access standards:

3.4.1 Primary Care:

a. Well care visits: Not to exceed thirty (30) calendar days;
b. Routine sick visits: Not to exceed seven (7) calendar days; and
c. Urgent care visits: Not to exceed twenty-four (24) hours.

3.4.2 Specialty Care:

a. Not to exceed forty-five (45) calendar days.

3.4.3 Dental Providers:

a. Routine visits: Not to exceed forty-five (45) calendar days; and
b. Urgent care visits: Not to exceed forty-eight (48) hours.

3.4.4 Behavioral Health Services

a. Routine Visits: Not to exceed twenty-one (21) calendar days;

b. Urgent Care Visits: Not to exceed twenty-four (24) hours; and

c. Post-discharge from an acute psychiatric hospital when the CCO is aware of the Covered Person's discharge: Not to exceed seven (7) calendar days.

3.4.5 Urgent Care: Not to exceed twenty-four (24) hours.

3.4.6 Emergency Care: Immediately, on a 24-hour basis, seven days a week and without prior authorization.

If Provider is a physician, Provider shall maintain hospital admitting privileges with a hospital that is a Participating Provider as required for the performance of his or her practice or shall have a written agreement with another Participating Provider who is a physician who has such hospital-admitting privileges.

Provider must be accessible to Covered Persons and must maintain a reasonable schedule of operating hours.

Provider acknowledges and agrees that the Division shall have the right to periodically review the adequacy of service locations and hours of operation, and will require corrective action to improve Covered Persons' access to services.

3.5 **State Authority.** Provider agrees and acknowledges that the Division shall have the right to invoke any remedy available under MississippiCAN Contract against Provider that it may bring against CCO, including b but not limited the right to terminate the Agreement.

3.6 **Compliance with Federal Law.** Provider shall comply with all applicable standards, order or requirements issued under Section 306 for the Clean Air Act (42 USC 1857(h)). Section 508 of the Clean Water Act (33 USC 1368), Executive Order 11738, Environmental Protection Agency regulations (40 CFR part 15) and 42 C.F.R. §438.

3.7 **Program Exclusion.** In the event Provider is excluded from participation by Medicare or Medicaid, including any other state's Medicaid or SCHIP program, CCO shall have no obligation to reimburse Provider for services other than Emergency Care rendered on or after the effective date of Provider's exclusion. Provider shall screen its employees for excluded persons. CCO shall immediately terminate Provider in the event Provider is excluded from participation in Federal health care programs under either Section 1128 or Section 1128A of the Social Security Act.

3.8 **Behavioral Health Services.** Covered Persons receiving inpatient psychiatric services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge from the inpatient psychiatric hospital if the CCO is aware of the Covered Person's inpatient hospitalization status.

3.9 **No Restriction on Health Status Advice**. Nothing herein shall be construed as prohibiting Provider, when acting within the lawful scope of practice, from discussing Medically Necessary care with a Covered Person, or advising or advocating appropriate medical care with or on behalf of a Covered Person about (i) the Covered Person's health status, medical care or treatment options, including any alternative treatment, alternative therapies, consultation or tests that may be self-administered; (ii) any information the Covered Person needs in order to decide among all relevant treatment options; (ii) the risks, benefits, and consequences of treatment or non-treatment; (iv) the Covered Person's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions; or (v) that the Covered Person may be responsible for non-Covered Services only if the Provider ensures that written documentation in compliance with the Advance Beneficiary Notification (ABN) is received from the Covered Person that the item or service rendered is a non-Covered Service and that the Covered Person will be financially responsible for the item(s) and/or service(s).

3.10 **PCP Responsibilities.** If Provider is a PCP, Provider shall comply with the following:

3.10.1 EPSDT Screenings.

3.10.1.1 PCPs who provide Covered Services to Covered Persons under the age of twenty-one (21) are responsible for conducting all EPSDT screens for individuals on their Panel under the age of twenty-one (21). Should the PCP be unable to conduct the necessary EPSDT screens, the PCP is responsible for arranging to have the necessary EPSDT screens conducted by another Participating Provider and ensure that all relevant medical information, including the results of the EPSDT screens, are incorporated into the Covered Person's PCP Medical Record.

3.10.1.2 PCP is responsible for contacting new Covered Persons identified in the quarterly encounter lists sent by CCO that indicate who has not had an encounter during the first six (6) months of Enrollment. Further, PCP shall:

3.10.1.2.1 Contact Covered Persons identified in the quarterly encounter lists as not complying with EPSDT periodicity and immunization schedules for children;

3.10.1.2.2 Identify to the CCO any such Covered Persons who have not come into compliance with the EPSDT periodicity and

immunization schedules within one (1) month of such notification to the site by the CCO; and

3.10.1.2.3 Document the reasons for noncompliance, where possible, and document the PCP's efforts to bring the Covered Person's care into compliance with the standards.

3.10.1.3 PCP shall provide periodic health screenings and appropriate and up-to date immunizations using the ACIP Recommended Immunization Schedule of all Covered Persons age one (1) or under one (1), in accordance with the Periodicity Schedule established for EPSDT services, including periodic examinations for vision, dental, and hearing and all Medically Necessary services. The following minimum elements must be included in the p eriodic health screening assessment:

a. Comprehensive health and development history (including assessment of both physical and mental development);

b. Measurements (including head circumference for infants);

c. Comprehensive unclothed physical examination;

d. Immunizations appropriate to age and health history;

e. Assessment of nutritional status;

f. Laboratory tests (including tuberculosis screening and Federally required blood lead screenings);

g. Vision screening;

h. Hearing screening;

i. Dental and oral health assessment;

j. Developmental assessment; and

k. Health education and anticipatory guidance.

If a suspected problem is detected by a screening examination, the child must be evaluated as necessary for further diagnosis. This diagnosis is used to determine treatment needs.

3.10.2 Specialists as PCPs. Covered Persons with disabling conditions, chronic illnesses, or child(ren) with special health care needs may request that their PCP be a specialist. The designation of a specialist as a PCP must be pursuant to a treatment plan approved by CCO; in consultation with the PCP to which the Covered Person is currently assigned, the Covered Person, and, as appropriate, the specialist. When possible, the specialist must be a Participating Provider. The specialist as a PCP must agree to provide or arrange for all primary care, including routine preventive care, and to provide those specialty medical services consistent with the Covered Person's disabling condition, chronic illness, or special health care need in accordance with CCO's standards and within the scope of the specialty training and clinical expertise. In order to accommodate the full spectrum of care, the specialist as a PCP must also have admitting privileges at a hospital that is a Participating Provider.

3.11 **Exclusion of Provider due to Patients with Expensive Medical Conditions.** CCO shall not exclude or terminate Provider from participation in CCO's Provider Network due to the facts that the Provider has a practice that includes a substantial number of patients with expensive medical conditions.

3.12 **Healthcare Opinions and Counsel.** Covered Persons are entitled to the full range of their health care Providers' opinions and counsel about the availability of Medically Necessary services under the provisions of the MississippiCAN Contract.

3.13 **No Termination of Contract or Employment.** CCO cannot terminate a contract or employment with Provider for filing a Complaint, Grievance, or Appeals on a Covered Person's behalf.

3.14 **Compliance with the Quality Management and Utilization Management Programs.** Provider shall comply with the quality management and utilization management program standards outlined in Section 9, "Quality Management", of the MississippiCAN Contract.

3.15 **Continuation of Care Under Capitation Arrangements**. If this Agreement provides for reimbursement of Provider on a capitation basis, should the Provider terminate this Agreement for any reason, Provider will provide Covered Services to Covered Persons assigned to the Provider under the Agreement up to the end of the month in which the effective date of termination falls.

3.16 **Confidentiality**. Provider must comply with all applicable laws and regulations pertaining to the confidentiality of Covered Person's Medical Records, including obtaining any required written Covered Person consents to disclose confidential Medical Records.

3.17 **Referrals.** Provider shall make referrals for social, vocational, education or human services when a need for such service is identified.

3.18 **Insolvency.** In the event CCO becomes insolvent or unable to pay Provider, Provider shall not seek compensation for services rendered from the State, its officers, Agents, or employees, or the Covered Persons or their eligible dependents.

3.19 **Claims Submission.** Provider must submit claims within a six (6) months from the date of service. Claims filed within the appropriate time frame but denied may be resubmitted to CCO within ninety (90) calendar days from the date of denial.

3.20 **Prohibition Against Intentional Segregation.** Provider shall not intentionally segregate Covered Persons in any way from other persons receiving services and shall provide Covered Services without regard to race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual orientation, language, health status, disease or pre-existing condition (including genetic information), anticipated need for health care or physical or mental handicap, except where medically indicated. Examples of prohibited practices include, but are not limited to, the following:

a. Denying or not providing a Covered Person any Covered Service or availability of Participating Provider. Health care and treatment necessary to preserve life must be provided to all Covered Person who are not terminally ill or permanently unconscious, except where a competent Covered Person objects to such care on his/her own behalf.

b. Subjecting a Covered Person to segregated, separate, or different treatment, including a different place or time from that provided to other Covered Persons, public or private patients, in any manner related to the receipt of any Covered Service, except where Medically Necessary.

c. The assignment of times or places for the provision of services on the basis of the race, color, creed, religion, age, sex, national origin, ancestry, marital status, sexual orientation, income status, program membership, language, health status, disease or pre-existing condition, anticipated need for health care or physical or mental disability of the Covered Persons to be served.

3.21 **Provider Preventable Conditions.** CCO shall not pay a Provider for a "Provider Preventable Condition" as defined by the federal regulations and the State Plan in accordance with 42 C.F.R. §438.6(b). Provider shall provide CCO with immediate written notice of any Never-Event, which notice shall include any such information relating to the Never-Event as is required by CCO to provide accurate and complete reporting to the Division regarding such Never-Event. CCO shall deny payment of any claims submitted for payment for a Never-Event.

3.22 **Compliance with State and Federal Disclosure Requirements**. Immediately upon Provider's knowledge of the same, Provider shall submit to CCO, in connection with any person who has an ownership or control interest in Provider, or who is an agent or managing employee of Provider (as defined by 42 C.F.R. § 455.101): i) notice that such person has been excluded from the Medicare and Medicaid programs for any reason; and

ii) the information required under 42 C.F.R. § 455.106 where such individual has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the title XX services program since the inception of those programs. Such disclosure must be in compliance with § 1128, as amended, of the Social Security Act, 42 USC §1320a-7, as amended, and 42 C.F.R. § 455.106. Federal regulations contained in 42 CFR § 455.104 and 42 CFR § 455.106 also require disclosure of all entities with which Provider has an ownership or control relationship. Provider shall provide information concerning each person with ownership or control, and shall submit to CCO, immediately upon request, any and all information necessary for CCO to make all required disclosures under 42 C.F.R. § 455.104 and § 455.106. CCO shall be entitled to, and shall, terminate or revoke this Agreement for cause for any reasons set forth in 42 C.F.R. §§ 455.420, 1001.1001 and Miss. Code Ann. § 43-13-121(7). Provider must make all disclosures required under 42 C.F.R. § 1002.3.

3.23 **Ongoing Course of Treatment**. Unless the Provider is being terminated for cause, Provider must allow a Covered Person to continue an ongoing course of treatment from the Provider for up to sixty (60) calendar days from the date the Covered Person is notified by COO of the termination or pending termination of Provider, or for up to sixty (60) calendar days from the date of Provider termination, whichever is greater. A Covered Person is considered to be receiving an ongoing course of treatment from Provider under the following circumstances: i) during the previous twelve (12) months, the Covered Person was treated by Provider for a condition that requires follow-up care or additional treatment or the services have been prior authorized; ii) an adult Covered Person with a previously scheduled appointment shall be determined to be in receipt of an ongoing course of treatment from the Provider, unless the appointment is for a well adult check-up; iii) any child (under age 21) with a previously scheduled appointment, including an appointment for well child care, shall be determined to be in receipt of an ongoing course of treatment from Provider; or iv) a Covered Person who is pregnant may continue to receive care from Provider through the completion of the Covered Person's postpartum care. Such transitional period may be extended by CCO if the extension is determined, in consultation with the Covered Person and Provider, to be clinically appropriate. To be eligible for payment for Covered Services provided to a Covered Person after Provider is terminated from the network, Provider must agree to meet the same terms and conditions as Participating Providers.

3.24 **Clinical Guidelines**. Provider shall comply with CCO's clinical guidelines. Provider acknowledges and agrees that CCO will, as required under the MississippiCAN Contract, annually measure Provider's performance against at least two (2) such clinical guidelines, and Provider shall take corrective actions where necessary to ensure compliance with the guidelines.

3.25 **Member Rights.** Provider shall comply with any applicable Federal and State laws that pertain to Member rights.

3.26 **Encounter Data**. Provider must submit to CCO accurate and timely encounter data in compliance with CCO's Provider Manual and/or encounter policies and procedures.

3.27 **Credentialing**. Provider shall all times during the term of the Agreement be properly licensed in accordance with all applicable State law and regulations, be eligible to participate in the Medicaid program, and have in effect appropriate policies of malpractice insurance as may be required by CCO and/or the Division. Provider must also be enrolled in the Mississippi Medicaid program using the same National Provider Identifier (NPI) numbers. Providers who are nurse practitioners acting at PCPs shall be held to the same requirements and standards as physicians acting at PCPs. In connection with these requirements, Provider shall furnish CCO with a copy of the Provider's current license issued by the State, cover page of malpractice insurance, and such additional information as may be specified by the Division.

ARTICLE IV
STATE MANDATED REQUIREMENTS

4.1 **Termination**. If Provider terminates the Agreement for any reason, Provider shall give CCO at least sixty (60) days prior written notice of such termination.

4.2 **Non-Assignment.** The 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 CCO.

AMBETTER FROM MAGNOLIA HEALTH PLAN/ COMMERCIAL-EXCHANGE AMENDMENT TO MISSISSIPPI PHYSICIANS CARE NETWORK PHYSICIAN SERVICE AGREEMENT

This Amendment ("***Amendment***") is entered into as of _____ by Mississippi Physicians Care Network, Inc. ("***MPCN***") and _____ ("***Participating Physician***"), collectively referred to herein as the "Parties."

WHEREAS, MPCN and Participating Physician have previously entered into a Mississippi Physicians Care Network Physician Service Agreement (the "***Agreement***") as of _____;

WHEREAS, in accordance with such Agreement, MPCN has entered into a contract with Magnolia Health Plan, Inc. ("***CCO***") so that CCO becomes a Payor, as that term is defined in the Agreement; and

WHEREAS, the Parties desire to amend the Agreement (i) to include Participating Physician and Contracted Providers (as hereafter defined) as participating providers in the "***Commercial-Exchange Product***," as defined and described in this Amendment and Attachment, and (ii) to add the Commercial-Exchange Product Attachment (as defined below) as a binding attachment to the Agreement.

NOW THEREFORE, in consideration of the promises and mutual covenants herein contained, the Parties agree as follows:

1. Effective Date. This Amendment is effective as of _____, 20___ ("***Effective Date***").

2. Commercial-Exchange Product Attachment. The attached "Commercial-Exchange Product Attachment," and all attachments thereto, are hereby incorporated into the Agreement.

3. Definitions.

3.1 Existing Terms. All capitalized terms not specifically defined in this Amendment will have the meanings given to such terms in the Agreement. For purposes of this Commercial-Exchange Product only, Article I of the Agreement is hereby amended by deleting the definitions in the Agreement for the following quoted terms and inserting in lieu thereof the definitions set forth below.

"***Beneficiaries***" means Covered Persons.

"***Covered Person***" means any individual entitled to receive Covered Services pursuant to the terms of a Coverage Agreement.

"***Covered Services***" means those services and items for which benefits are available and payable under the applicable Coverage Agreement and which are determined, if applicable, to be medically necessary under the applicable Coverage Agreement.

"***Emergency,***" "***Emergency Care***" and "***Emergency Medical Condition***" have the meanings set forth in the Covered Person's Coverage Agreement. If no such definition exists, such terms shall have the meanings set forth in the Agreement.

"***Medically Necessary***" has the meaning set forth in the Covered Person's Coverage Agreement. If no such definition exists, such terms shall have the meanings set forth in the Agreement.

"***Participating Provider***" means, with respect to a particular Product, any physician, hospital, ancillary, or other health care provider that has contracted, directly or

indirectly, with CCO or Payor to provide Covered Services to Covered Persons, and that is designated by CCO or Payor as a "participating provider" in such Product.

"***Payor***" means the entity that bears direct financial responsibility for paying from its own funds, without reimbursement from another entity, the cost of Covered Services rendered to Covered Persons under a Coverage Agreement.

3.2 New Terms. For purposes of this Commercial-Exchange Product only, Article I of the Agreement is hereby amended by adding the new defined terms and definitions set forth below.

"***Compensation Schedule***" means at any given time the then effective schedule(s) of maximum rates applicable to the Commercial-Exchange Product under which Participating Physician will be compensated for the provision of Covered Services to Covered Persons. Such Compensation Schedule(s) will be set forth or described in an exhibit to the Commercial-Exchange Product Attachment.

"***Commercial-Exchange Product***" means those programs and health benefit arrangements offered by or available from or through CCO or a Payor that provide incentives to Covered Persons to utilize the services of certain contracted providers. The Commercial-Exchange Product includes those Coverage Agreements entered into, issued or agreed to by a Payor under which CCO, its affiliate, or its delegate furnishes administrative services or other services in support of a health care program for an individual or group of individuals, which may include access to one or more of the CCO's or Payor's provider networks or vendor arrangements, and which may be provided in connection with a state or governmental-sponsored, employer-sponsored, or other private health insurance exchange. The Commercial-Exchange Product does not apply to any Coverage Agreements that are specifically covered by another Product Attachment to the Agreement.

"***Contracted Provider***" means a physician, hospital, health care professional or any other provider of items or services that (i) is employed by or has a contractual relationship with Participating Physician, and (ii) has been approved for participation by CCO. The term "Contracted Provider" includes Participating Physician for those Covered Services provided by Participating Physician and for which Participating Physician has been approved for participation by CCO.

"***Coverage Agreement***" means any agreement, program or certificate entered into, issued or agreed to by a Payor, under which the Payor arranges for the delivery of health care services to Covered Persons through one or more network(s) of providers or other vendor arrangements.

"Payor Contract" means the contract with a Payor, pursuant to which CCO or its affiliate furnishes administrative services or other services in support of the Coverage Agreements entered into, issued or agreed to by a Payor, which services may include access to one or more of provider networks or vendor arrangements of CCO or its affiliate. The term "Payor Contract" includes a contract with a governmental authority (also referred to herein as a "Governmental Contract") under which CCO, its affiliate or Payor arranges for the provision of Covered Services to eligible individuals.

"***Provider Manual***" means the manuals, requirements, policies and procedures adopted by the CCO, its affiliate, Payor, or its delegate to be followed by Participating Providers, including, without limitation, those relating to utilization management, quality management, grievances and appeals, and Product-specific, Payor-specific and State-

specific requirements, as the same may be amended from time to time by the CCO, its affiliate, Payor or its delegate.

"***Product***" means any program or health benefit arrangement designated as a "product" by MPCN, CCO or a Payor (e.g., Medicaid Product, Commercial-Exchange Product, Payor-specific Product, etc.) that is now or hereafter offered by or available from or through CCO, its affiliate or a Payor that provides Covered Persons in such product with incentives or access to Participating Providers in such product. For purposes of the Commercial-Exchange Product Attachment, "Product" means the Commercial-Exchange Product.

"***Product Attachment***" means an Attachment setting forth certain requirements, terms and conditions specific to one or more Products, including certain provisions that must be included in a provider agreement under the laws of the State, which may be alternatives to, or in addition to, the requirements, terms and conditions set forth in the Agreement or the Provider Manual.

"***Regulatory Requirements***" means all applicable statutes, regulations, regulatory guidance, judicial or administrative rulings, requirements of Governmental Contracts and standards and requirements of any accrediting or certifying organization, including, but not limited to, the requirements set forth in a Product Attachment.

"State" means the State of Mississippi, unless otherwise defined in an Attachment for purposes of that Attachment.

4. The following is added to Section 13.5 of the Agreement: Notwithstanding the foregoing, in the event that the contract between MPCN and CCO terminates for any reason or MPCN becomes insolvent, MPCN and Participating Physician agree to the partial assignment of the Agreement to CCO such that CCO shall assume those rights and responsibilities as a Payor under the Agreement and Participating Physician's rights and responsibilities under the Agreement pursuant to such partial assignment shall be limited to those rights owed by, and responsibilities due to, CCO as a Payor under the Agreement. In no event shall CCO assume any of MPCN's rights and responsibilities under the Agreement as a result of such partial assignment. MPCN and Participating Physician agree to execute any necessary documents in order to effectuate such partial assignment.

5. An Article XV shall be added to the Agreement as follows:

ARTICLE XV
Magnolia Health Plan and Commercial-Exchange Requirements

15.1 **Access to Records**. Participating Physician agrees that CCO has access to medical records, to the extent permitted by state and federal laws.

15.2 **Communication regarding Treatment**. Participating Physician may freely communicate with patients about their treatment, regardless of benefit coverage limitations.

15.2.1 Provision of Services. Participating Physician shall ensure that waiting periods for appointments or waiting periods for services for CCO Beneficiaries once an appointment is made shall comply with Regulatory Requirements. For purposes of this Amendment, "Regulatory Requirements" shall be defined as any applicable rule, regulation, statute or other binding legal guidance or directives issued by a State Agency (which for purposes of this Amendment shall mean the applicable State Medicaid Agency or other applicable governmental agency or division), or federal agency, or any applicable contractual provision in any State Contract

(which for purposes of this Amendment shall mean a written agreement entered into between the CCO and an applicable State Agency pursuant to which CCO has agreed to arrange to provide Covered Services to CCO Beneficiaries) or other applicable contract between CCO and a federal government agency. If applicable, Participating Physician shall also ensure that Covered Services provided or arranged for under this Agreement are available on a basis of twenty-four (24) hours a day, seven (7) days a week, as the nature of the CCO Beneficiary's condition dictates.

15.3 **Notice to CCO Beneficiaries of Specialist Termination**. If Participating Physician is a specialist or specialty group practice and this Agreement or Amendment is terminated, Participating Physician shall provide written notice within thirty (30) business days of receipt, or issuance of a notice of termination, to all CCO Beneficiaries who are seen on a regular basis by Participating Physician, regardless of whether the termination was for cause or without cause

15.4 **Compliance with CCO's Provider Manual**. Participating Physician shall at all times cooperate and comply with CCO's Provider Manual.

15.5 **Compliance with CCO's Hold Harmless Provision.** Participating Physician agrees to comply with CCO's hold harmless requirements contained in Exhibit 1 of the Commercial-Exchange Product Attachment (Regulatory Requirements).

15.6 **Determination of CCO Beneficiary Eligibility.** Participating Physician shall determine whether a person seeking Covered Services is a CCO Beneficiary. If Participating Physician determines that such person was not eligible for coverage at the time the services were rendered, such services shall not be eligible for payment under this Agreement, and Participating Physician may bill the affected person directly for such services at the applicable rates to the extent permitted by Regulatory Requirements.

15.7 **Notification of Emergency Services**. If applicable, Participating Physician agrees to accommodate CCO Beneficiary emergencies on the same basis that Participating Physician would accommodate emergencies with respect to a person covered under any other plan of benefits, and to provide Medically Necessary Emergency Care to CCO Beneficiaries. Participating Physician shall notify CCO within twenty-four (24) hours or by the next business day of rendering or learning of the rendering of Emergency Care to a CCO Beneficiary.

15.8 **Acceptance of New Patients.** To the extent that any Participating Physician is accepting new patients, such Participating Physician must also accept new patients who are CCO Beneficiaries. In no event shall any established patient of a Participating Physician who becomes a CCO Beneficiary be considered a new patient.

15.9 **Referrals.** Participating Physician providing services upon referral shall, in accordance with the requirements of CCO's Provider Manual, make a report to the CCO Beneficiary's Primary Care Physician (PCP). Participating Physician shall immediately refer all CCO Beneficiaries with known or suspected physical health problems or disorders to their primary care provider for examination and treatment. Participating Physician shall provide only those health care services that fall within the scope of their licenses.

15.10 **Drug Formulary.** Participating Physician shall abide by CCO's drug formulary when prescribing medications for CCO Beneficiaries in accordance with CCO's Provider Manual.

15.11 **Participating Physician Responsibilities.** Each Participating Physician shall establish a provider/patient relationship with each CCO Beneficiary that such individual treats. Each Participating Physician shall at all times maintain control over the diagnosis and treatment of CCO Beneficiary and responsibility for providing services under this Agreement in a manner which: (i) is compatible with accepted professional standards of medical care and medical ethics prevailing in the community; (ii) emphasizes preventative care and health maintenance; and (iii) at all times is rendered to CCO Beneficiaries in a dignified, exemplary, and non-discriminatory manner. CCO shall not be liable for, nor will it exercise control over, the manner or method by which any Participating Physician provides or arranges for Covered Services under this Agreement. CCO's determinations (if any) to deny payments for services which CCO does not deem to constitute Covered Services or which were not provided in accordance with the requirements of this Agreement, the Attachments or CCO's Provider Manual, are administrative decisions only. Notwithstanding any language in this Agreement, any Attachment or CCO's Provider Manual to the contrary, such a denial does not absolve any Participating Physician of his/her responsibility to exercise independent judgment in the provision of care and treatment to CCO Beneficiaries and in no way limits or restricts any Participating Physician's ability to provide or recommend treatment which he/she believes is necessary for the appropriate care and treatment of any patient.

15.11.1 Non-Discrimination. Participating Physician agrees that there shall be no discrimination between or intentional segregation of CCO Beneficiaries by Participating Physician and any other patients of Participating Physician, and that Participating Physicians shall provide Covered Services without regard to race, color, religion, sex, national origin, ancestry, age, physical or mental disability, type of CCO benefit coverage, or Payor, or source of payment.

15.12 **Utilization Management Program.** Participating Physician shall cooperate with, participate in, and abide by the decisions of any utilization review programs established by CCO or the State Agency. Participating Physician acknowledges and agrees that the failure to comply with this section and said programs shall be grounds for denial of payment.

15.13 **Grievance & Appeals Procedures.** Participating Physician shall cooperate with CCO's Beneficiary and Provider grievance and appeals procedures, and Participating Physician shall agree that all communications and documents relating to benefit determinations, complaints, and grievances and records relating to such problems shall be referred to CCO in accordance with the grievance procedures.

15.14 **Written Notice**. Participating Physician shall give written notice to CCO of: (i) any action involving Participating Physician's hospital privileges or conditions relating to Participating Physician's ability to admit patients to any hospital or inpatient facility; (ii) any situation which develops regarding Participating Physician, when notice of that situation has been given to the state agency that licenses Participating Physician, or any other licensing agency or board, or any situation involving an investigation or complaint filed by the state agency that licenses Participating Physician, or any other licensing agency or board, regarding a complaint against Participating Physician's license; (iii) when a change in Participating Physician's license to practice medicine is affected or any form of reportable discipline is taken against such license; (iv) suspension or exclusion under a federal health care program, including but not limited to, Medicaid; (v) any government agency request for access to records; or (vi) any adverse determination in connection with a lawsuit or claim filed or asserted against Participating Physician alleging professional malpractice, regardless of whether the lawsuit or claim involves a CCO Beneficiary. In any such instance described above, Participating Physician must notify CCO in writing

within ten (10) days from the date he or she first receives notice, whether written or oral, with the exception of those lawsuits or claims which do not involve a CCO Beneficiary, with respect to which Participating Physician has thirty (30) days to notify CCO.

15.15 **Timely Filing**. CCO shall pay or deny in accordance with the Provider Manual.

15.16 **Termination**.

A. Participating Physician's participation with CCO may be terminated immediately upon written notice by CCO if there is imminent harm to patient health or fraud or malfeasance is suspected.

B. Participating Physician's participation may be terminated without cause and at any time upon ninety (90) days prior written notice to Participating Physician.

C. Participating Physician's participation may be terminated without cause and at any time upon ninety (90) days prior written notice to CCO and MPCN.

15.17 **Recoupment**. CCO shall have the right to immediately recoup any and all amounts owed by Participating Physician to CCO against amounts owed by CCO to Participating Physician. Such recoupment by CCO is limited to the twelve (12) months after the payment was initially made except in cases where the overpayment resulted from fraud or abuse by or on behalf of Participating Physician, or when CCO's ability to discover the overpayment during the twelve (12) month period was hindered by Participating Physician's failure to provide full and timely cooperation with an audit by CCO. Participating Physician 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 Participating Physician.

15.18 **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 CCO's Provider Manual, if applicable, 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 by providing written notice to the other party. Either party wishing to pursue such a 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 aforementioned sixty (60) day negotiation period. Arbitrations 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.

6. Conflict. All other terms and conditions of the Agreement and any amendments thereto, if any, shall remain in full force and effect. If the terms of this Amendment conflict with any of the terms of the Agreement, the terms of this Amendment shall prevail for Covered Services provided to CCO Beneficiaries only. The terms and conditions of this Amendment shall apply only with regard to Covered Services provided to CCO Beneficiaries.

[**SIGNATURE BLOCK FOLLOWS]**

IN WITNESS WHEREOF, the Parties hereto have executed and delivered this Ambetter from Magnolia Health Amendment as of the first date set forth above.

Mississippi Physician Care Network:

Authorized Signature

_____
Signature

_____
Printed Name

_____
Title

Date_____

Provider:

Authorized Signature

_____
Signature

_____
Printed Name

_____
Title

Date_____

Tax ID Number_____

Individual NPI Number_____

Group NPI Number_____

Medicaid ID Number_____

MAGNOLIA HEALTH PLAN
COMMERCIAL-EXCHANGE PRODUCT ATTACHMENT

This Commercial-Exchange Product Attachment ("Product Attachment") is incorporated into the Agreement between Participating Physician and MCO. It supplements the Agreement by setting forth specific terms and conditions that apply to the Commercial-Exchange Product with respect to which a Participating Provider has agreed to participate, and with which a Participating Provider must comply in order to maintain such participation.

1. Product Attachment. This Section 2 constitutes the "Commercial-Exchange Product Attachment" ("***Product Attachment***") and is incorporated into the Agreement between Participating Physician and CCO. It supplements the Agreement by setting forth specific terms and conditions that apply to the Commercial-Exchange Product with respect to which a Participating Provider has agreed to participate, and with which a Participating Provider must comply in order to maintain such participation.

2. Participation.

(a) Unless otherwise specified in this Product Attachment and as limited by Section 2.2(b) below, all Contracted Providers will participate in the Commercial-Exchange Product as "Participating Providers," and will provide to Covered Persons enrolled in or covered by a Commercial-Exchange Product, upon the same terms and conditions contained in the Agreement, as supplemented or modified by this Product Attachment, those Covered Services that are provided by Contracted Providers pursuant to the Agreement. In providing such services, Participating Physician shall, and shall cause Contracted Providers to, comply with and abide by the provisions of the Agreement, including this Product Attachment and the Provider Manual.

(b) Participating Physician and each Contracted Provider may only identify himself, herself or itself as a Participating Provider for those Commercial-Exchange Products in which the Participating Physician or Contracted Provider actually participates as provided in the Agreement and this Product Attachment. Participating Physician acknowledges that CCO, its affiliate or a Payor may have, develop or contract to develop various Commercial-Exchange Products or provider networks that have a variety of provider panels, program components and other requirements, and that all or certain of CCO's duties with respect to the Commercial-Exchange Product may be delegated to an affiliate of CCO, a Payor or their delegates. Neither CCO nor any Payor warrants or guarantees that Participating Physician or any Contracted Provider: (i) will participate in all or a minimum number of provider panels, (ii) will be utilized by a minimum number of Covered Persons, or (iii) will indefinitely remain a Participating Provider or member of the provider panel for a particular network or Commercial-Exchange Product.

3. Attachment. This Product Attachment includes, at Exhibit 1, the Regulatory Requirements with which Participating Providers are required to comply in connection with their participation in the Commercial-Exchange Product. Any additional Regulatory Requirements that may apply to Participating Providers are or will be set forth in the Provider Manual or another Attachment and are incorporated herein by this reference. This Product Attachment also includes a Compensation Schedule at Exhibit 2.

4. Term. The term of the Participating Providers' participation in the Commercial-Exchange Product will commence as of the Effective Date and, thereafter, will be coterminous with the term of the Agreement unless a party terminates the participation of the Participating Provider in the Commercial-Exchange Product in accordance with the applicable provisions of the Agreement or this Product Attachment. In addition to the termination rights in the Agreement, the participation of any Contracted Provider as a "Participating Provider" in the Commercial-Exchange Product may terminated by either party giving the other party at least ninety (90) days' prior written notice of such termination; in such event, Participating Physician shall immediately notify the affected Contracted Provider of such termination.

5. Conflict and Construction. This Product Attachment modifies, supplements and forms a part of the Agreement. Except as otherwise provided in this Product Attachment, the terms and conditions of the Agreement will remain unchanged and in full force and effect. In the event of any conflict or inconsistency between the provisions of the Agreement (or any other Attachment) and the provisions of this Product Attachment, the terms and conditions of this Product Attachment will govern with respect to health care services, supplies or accommodations (including Covered Services) rendered to Covered Persons enrolled in or covered by the Commercial-Exchange Product. To the extent Participating Physician or any Contracted Provider is unclear about its, his or her respective duties and obligations, Participating Physician or the applicable Contracted Provider shall request clarification from CCO.

EXHIBIT 1 TO THE COMMERCIAL-EXCHANGE PRODUCT ATTACHMENT

REGULATORY REQUIREMENTS

This Exhibit sets forth the provisions that are required by State or federal law to be included in the Agreement with respect to the Commercial-Exchange Product. To the extent that a Payor, Coverage Agreement, or Covered Person is subject to the law cited in the parenthetical at the end of a provision on this Exhibit, such provision will apply to the rendering of Covered Services to a Covered Person of such Payor, to a Covered Person with such Coverage Agreement, or to such Covered Person, as applicable.

MS-1 Hold Harmless. Participating Physician and each Contracted Provider agree that if the Payor fails to pay for health care services as set forth in the Agreement, the Covered Person shall not be liable to the Participating Physician or Contracted Provider for any sums owed by the Payor. Participating Physician and each Contracted Provider agree that the Participating Physician and Contracted Provider, and any agent, trustee or assignee of the same, shall not maintain any action at law against a Covered Person to collect sums owed by the Payor. (MISS CODE ANN. §§ 83-41-325(13), 83-41-325(15))

MS-2 Continuity of Care. Participating Physician and each Contracted Provider agree that in the event of insolvency of the Payor, the Participating Provider will continue to provide services to each Covered Person for the duration of the period after the Payor's insolvency for which premium payment has been made and until the Covered Person's discharge from inpatient facilities. (MISS CODE ANN. § 83-41-325(16)(b))

MS-3 Termination. If Participating Physician terminates the Agreement or his, her or its participation under the Product Attachment, Participating Physician shall give CCO at least sixty (60) days' advance written notice of termination. (MISS CODE ANN. § 83-41-325(17))

MS-4 Examination. Participating Physician and each Contracted Provider agree that (a) the Commissioner of Insurance may make an examination of the affairs of Participating Physician and each Contracted Provider as often as is reasonably necessary for the protection of the interests of the people of this State; and (b) the State Health Officer may make an examination concerning the quality assurance shall make an examination of the affairs of Participating Physician and each Contracted Provider as often as is reasonably necessary for the protection of the interests of the people of this State. Participating Physician and each Contracted Provider shall submit his, her or its books and records for such examination and in every way facilitate the completion of the examination. Participating Physician and each Contracted Provider agree that, for the purpose of examinations, the Commissioner of Insurance and the State Health Officer may administer oaths to and examine the principals of Participating Physician and each Contracted Provider concerning its, his or her business in accordance with existing insurance laws, rules and regulations. (MISS CODE ANN. § 83-41-337)

EXHIBIT 2 of the AMENDMENT

PROVIDER COMPENSATION SCHEDULE

COMMERCIAL-EXCHANGE PRODUCT
PROFESSIONAL SERVICES

For Covered Services provided to Covered Persons, Payor shall pay Provider the lesser of: (i) the Provider's Allowable Charges; or (ii) one hundred twenty-five percent (125%) of the Payor Medicare fee schedule in effect on the date of service and specific to the services rendered, less any applicable coinsurance or deductible. This fee schedule is based on the CMS/Medicare RBRVS relative values and for certain codes alternative fee sources may be used. This reimbursement rate will be in effect from January 1, 2015 through December 31, 2015.

Additional Provisions:

Fee Schedule Development. Payor Medicare fee schedule was established utilizing the 2012 CMS/Medicare RBRVS relative values and geographic practice cost index (GPCI) applicable to the state of Mississippi.

Fee Schedule Review. Payor shall perform an annual review and assessment of the Payor Medicare fee schedule and provide formal written communication to the Provider if any adjustments will be applied to the fee schedule that will impact overall reimbursement to the Provider.

Code Change Updates. Updates to existing billing-related codes shall become effective on the date ("Code Change Effective Date") that is the effective date of such code updates, as determined by such governmental agency. Claim processed prior to the Code Change Effective Date shall not be reprocessed to reflect any code updates.

Modifier. Unless specifically indicated otherwise, Fee Amounts listed in the fee schedule represent global fees and may be subject to reductions based on appropriate Modifier (for example, professional and technical modifiers). As used in the previous sentence, "global fees" refers to services billed without a Modifier, for which the Fee Amount includes both the professional component and the technical component. Any co-payment, deductible or coinsurance that the customer is responsible to pay under the customer's benefit contract will be subtracted from the listed Fee Amount in determining the amount to be paid by the payer. The actual payment amount is also subject to matters described in this agreement, such as the Payment Policies.

Fee Sources. In the event CMS contains no published fee amount, alternate (or "gap fill") Fee Sources may be used to supply the Fee Basis amount for deriving the Fee Amount. At such time in the future as CMS publishes its own RBRVS value for that CPT/HCPCS code, Payor will use the CMS fee amount for that code and no longer use the alternate Fee Source.

Anesthesia Modifier Pricing Rules. The dollar amount that will be used in the calculation of time-based and non-time based Anesthesia Management fees in accordance with the Anesthesia Payment Policy. Unless specifically stated otherwise, the Anesthesia Conversion Factor indicated is fixed and will not change. The Anesthesia Conversion Factor is based on an anesthesia time unit value of 15 minutes.

Multiple Procedure Pricing Rules. Multiple procedures performed during the same day will be reimbursed at 100% for the primary procedure, 50% for the second procedure, and 50% for the third procedure, subsequent procedures shall not be eligible for reimbursement.

Place of Service Pricing Rules. This fee schedule follows CMS guidelines for determining when services are priced at the facility or non-facility fee schedule (with the exception of services performed at Ambulatory Surgery Centers, POS 24, which will be priced at the facility fee schedule).

Fee Change Updates. Updates to such fee schedule for new codes shall become effective on the date ("Fee Change Effective Date") that is 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.

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

Note:

1. Except as modified or supplemented by this Attachment, the compensation set forth in this Exhibit for the provision of Covered Services to Covered Persons enrolled in or covered by the Commercial-Exchange Product is subject to all of the other provisions in the Agreement (including the Provider Manual) that affect or relate to compensation for Covered Services provided to Covered Persons.

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NOTE: Except as modified or supplemented by the Commercial-Exchange Product Attachment, the compensation set forth in this Exhibit 2 for the provision of Covered Services to Covered Persons enrolled in or covered by the Commercial-Exchange Product is subject to all of the other provisions in the Agreement (including the Provider Manual) that affect or relate to payment for Covered Services provided to Covered Persons.

MAGNOLIA HEALTH CHIP PRODUCT

As a benefit to Mississippi Physicians Care Network (MPCN) participating providers, MPCN is pleased to offer participation in the Magnolia Health CHIP program effective 7/1/2025. This product is an addition to our network options and allows MPCN providers to render services to Magnolia CHIP members without additional credentialing, as MPCN manages enrollment. The Magnolia Health CHIP contract is available upon request.

To participate in the Magnolia CHIP product, you must be a MS Medicaid provider and OPT-IN by completing the information below.

Enrollment is optional and does not affect your participation with MPCN.

If you need additional information, please email Don Foote at dfoote@mpcn-ms.com.

☐ **Yes, I would like to participate in Magnolia CHIP**

Individual Mississippi Medicaid provider ID: _____

Office Hours for practice locations: _____

Nurse Practitioners, please list certification: _____

_____ _____
(Practitioner Signature) **(Print Name)**

_____ _____
(Date) **(Tax ID)**

_____ _____
(Clinic/Group Name) **(Group NPI)**

_____ _____ ___ _____
(Street Address) **(City)** **(State)** **(Zip)**

To submit enrollment, return to:
MPCN Network Service/Magnolia Health CHIP
Email: dfoote@mpcn-ms.com or Fax: 601-605-4753

P.O. BOX 1530 RIDGELAND, MISSISSIPPI 39158-1530
TEL: 601.605.4756 FAX: 601.605.4753 www.mpcn-ms.com

WELLCARE MEDICARE ADVANTAGE PRODUCT

As a benefit to Mississippi Physicians Care Network (MPCN) participating providers, MPCN serves as a delegated credentialing entity for the WellCare Medicare Advantage market in Mississippi. This partnership has proven beneficial to MPCN providers who wish to service WellCare members, given additional credentialing is not required.

To participate in the WellCare Medicare Advantage product, you must be a MS Medicare provider and OPT-IN by completing the information below.

Enrollment is optional and does not affect your participation with MPCN.

If you need additional information, please email Don Foote at dfoote@mpcn-ms.com.

☐ **Yes, I would like to participate in WellCare Medicare Advantage Plan.**

Individual Mississippi Medicare provider ID: _____

Office Hours for practice locations: _____

Nurse Practitioners, please list certification: _____

_____ _____
(Practitioner Signature) **(Print Name)**

_____ _____
(Date) **(Tax ID)**

_____ _____
(Clinic/Group Name) **(Group NPI)**

_____ _____ ___ _____
(Street Address) **(City)** **(State)** **(Zip)**

To submit enrollment, return to:
MPCN Network Services/Wellcare Medicare Advantage
Fax: 601-605-4753 or Email: dfoote@mpcn-ms.com

P.O. BOX 1530 RIDGELAND, MISSISSIPPI 39158-1530
TEL: 601.605.4756 FAX: 601.605.4753 www.mpcn-ms.com

PRIMEWELL MA AND EXCHANGE PRODUCTS

MPCN has expanded our relationship with Primewell Health (Formerly Vantage Health Plan) to include their Exchange Product.

By joining through your MPCN agreement, you do not have to contract with, nor be credentialed by Primewell, as you are already contracted and credentialed with MPCN.

Enrollment is optional and does not affect your current participation with MPCN.

If you would like to participate in the Primewell MA Product and/or the Primewell Exchange Product, you may do so by simply OPTING IN and completing the information below.

If you need additional information, please email Don Foote at dfoote@mpcn-ms.com.

☐ **Yes, I would like to participate in Primewell Medicare Advantage Plan.**

☐ **Yes, I would like to participate in Primewell Exchange Plan.**

Individual Mississippi Medicare provider ID: _____

Office Hours for practice locations: _____

Nurse Practitioners, please list certification: _____

_____ (Practitioner Signature)

_____ (Print Name)

_____ (Date)

_____ (Tax ID)

_____ (Clinic/Group Name)

_____ (Group NPI)

_____ (Street Address)

_____ (City)

_____ (State)

_____ (Zip)

Please submit enrollment to Don Foote at:

Email: dfoote@mpcn-ms.com

OR FAX to Don Foote's attention: 601-605-4753.

P.O. BOX 1530 RIDGELAND, MISSISSIPPI 39158-1530
TEL: 601.605.4756 FAX: 601.605.4753 www.mpcn-ms.com

SHARED HEALTH PRODUCT

MPCN has entered into a Professional Provider Network Agreement with SHMS that sets forth the key terms, as summarized below, relating to MPCN's planned participation in the D-SNP Medicare Advantage product.

1. Plan Sponsor: Shared Health Mississippi, Inc.
2. Line of business: D-SNP Medicare Advantage
3. Effective Date: January 1, 2021
4. Rates: 100% of Original Medicare. Provider also may be eligible to participate in incentive programs to earn additional payments.

The Professional Provider Network Agreement is available upon request.

Provider Participation in Product

Unless a written objection is received from Provider within thirty (30) days of receiving this Product Notice, Provider shall be deemed to have acknowledged that this Product Notice meets the requirements of the Agreement for MPCN to include Provider as a participant in a new product.

Should you choose to not participate, please check the box below and provide requested information.

_☐_ **I choose to OPT OUT of the Shared Health program**

Provider's Name _____

Provider's Tax ID Number _____

American Health Advantage of Mississippi

American Health Advantage of Mississippi is a Provider Owned Health Plan that offers a Medicare Advantage Institutional Special Needs Plan (I-SNP) developed and managed by American Health Plans.

Important facts about our plans:

- Currently offered in 25 counties across Mississippi with anticipated growth into additional counties in 2023
- Only available to residents in skilled nursing facilities
- Uniquely designed to ensure that quality care is provided to fragile and underserved populations
- Includes a Model of Care that focuses on medical monitoring, skill-in-place care when appropriate, and the coordination of care with our members' medical providers.
- Pays 100% of the current Medicare Allowable Rate

Mississippi Physicians Care Network (MPCN) has signed an agreement with American Health Plans of Mississippi, Inc. and are requesting your participation in accordance with MPCN policy. **In order to participate in this product, you must OPT IN by signing and completing the information below.**

If you do not participate in the American Health Advantage product, you will still remain a member in the MPCN network. MPCN appreciates your participation in our network as well as all the support so many of you provide each year. If you need additional information, please email Don Foote at dfoote@mpcn-ms.com.

(continued on next page)

Yes, I will participate in the American Health Advantage of Mississippi product.

☐

_____

(*Signature*) (Tax ID)

_____

(*Print Name*) (Group NPI)

_____

(*Provider/Group Name*) (DATE)

_____

(*Address*)

_____

(*Telephone Number*)

Electronic signature honored.

Are you a Mississippi Medicare provider? Yes No Yes

If yes, you must provide Individual Medicare Number _____

Opt-In notices may be sent to: Don Foote at dfoote@mpcn-ms.com

See next page for a list of current hospitals participating in this product.

We appreciate your participation with American Health Advantage of Mississippi, Inc.

CURRENT LIST OF PARTICIPATING HOSPITALS:

ALLIANCE HEALTHCARE SYSTEM
ANDERSON REGIONAL MEDICAL CENTER
ANDERSON REGIONAL MEDICAL CENTER SOUTH CAMPUS
BAPTIST MEDICAL CENTER – LEAKE, ATTALA, AND YAZOO
BAPTIST MEMORIAL HOSPITAL-BOONEVILLE INC
BAPTIST MEMORIAL HOSPITAL-CALHOUN INC
BAPTIST MEMORIAL HOSPITAL-DESOTO
BAPTIST MEMORIAL HOSPITAL-GOLDEN TRIANGLE
BAPTIST MEMORIAL HOSPITAL-NORTH MISSISSIPPI INC
BAPTIST MEMORIAL HOSPITAL-UNION COUNTY
BEACHAM MEMORIAL HOSPITAL
BOLIVAR MEDICAL CENTER
CLAIBORNE COUNTY MEDICAL CENTER
FORREST GENERAL HOSPITAL
GEORGE REGIONAL HOSPITAL
GREENWOOD LEFLORE HOSPITAL
JASPER GENERAL HOSPITAL
LAWRENCE COUNTY HOSPITAL
MAGEE GENERAL HOSPITAL
MAGNOLIA REGIONAL HEALTH CENTER
MARION GENERAL HOSPITAL
MERIT HEALTH BILOXI
MERIT HEALTH CENTRAL
MERIT HEALTH MADISON
MERIT HEALTH NATCHEZ
MERIT HEALTH RANKIN
MERIT HEALTH RIVER OAKS
MERIT HEALTH RIVER REGION
MERIT HEALTH WESLEY
MERIT HEALTH WOMAN'S HOSPITAL
MISSISSIPPI BAPTIST MEDICAL CENTER
NESHOBA COUNTY GENERAL HOSPITAL
NORTH SUNFLOWER MEDICAL CENTER
REGENCY HOSPITAL OF MERIDIAN
SE LACKEY MEMORIAL HOSPITAL
SELECT SPECIALTY HOSPITAL GULFPORT
SELECT SPECIALTY HOSPITAL JACKSON
SELECT SPECIALTY HOSPITAL- BELHAVEN
SINGING RIVER HEALTH SYSTEM
SOUTH CENTRAL REGIONAL MEDICAL CENTER
SOUTH SUNFLOWER COUNTY HOSPITAL

SOUTHWEST MISSISSIPPI REGIONAL MEDICAL CENTER
WAYNE GENERAL HOSPITAL
WINSTON MEDICAL CENTER

Healthy Mississippi (Qualexa)

- MPCN has agreed to help Healthy Mississippi and affiliates to continue to build and expand their Medicare Network for their current 2025 Medicare Advantage product. Reimbursement is 100% of the Medicare fee schedule. They will also be expanding with additional plans in 2026.
- **MPCN in no way represents nor endorses this product**. In order to participate, YOU MUST **OPT IN** by filling out the information included. As with other products, by participating through your MPCN Agreement, you will not have to be credentialed, nor will you have to be contracted directly with Network.

A note from Healthy Mississippi/Qualexa:

WHY Healthy Mississippi?

1. State-wide Medicare Advantage Plan
2. Pays 100% of Medicare fee schedule
3. Pays timely consistent with CMS guidelines
4. Pays value-based care incentives to participating Providers
5. Opportunity for risk-sharing contracts for interested Providers
6. Streamlined Prior Authorization procedures
7. Low-cost mail order pharmacy located in the state of MS.

Should you choose NOT to OPT- IN, YOU WILL STILL REMAIN A PARTICIPATING PROVIDER IN THE MPCN NETWORK.

(continued on next page)

Provider agrees to Participate in Network and contract with Network with same terms and conditions as the MPCN Physician Service Agreement, and compliant with Medicare contract language (www.healthy-ms.com/mcrterms). The contracted reimbursement for Medicare Advantage members shall be 100% of the Medicare ("CMS") outpatient fee schedule.

In order to participate, you must Opt-In by providing the following information:

☐ **I choose to Opt In this product**

Provider name: _____

Provider Tax ID number: _____

Provider NPI number: _____

Provider Signature: _____

***For a group practice**, please attach the above information for each MPCN Contracted Practitioner in your clinic who wants to participate in this product.

Fax number – (601) 605-4753

For a summary of provider responsibilities, a provider manual, or more information, please email or call Don Foote. 601-605-4756 ext. 337 or dfoote@mpcn-ms.com.

****Healthy Mississippi is in the process of recruiting hospitals. Please provide us with your preferred hospitals, and where you have hospital privileges.**

TRUECARE MSCAN AND TRUECARE CHIP PRODUCTS

MPCN is pleased to partner with TrueCare, which includes both the MSCAN and CHIP programs. The TrueCare contract is available upon request.

By joining through your MPCN agreement, you do not have to contract with, nor be credentialed by TrueCare, as you are already contracted and credentialed through MPCN.

Enrollment is optional and does not affect your current participation with MPCN.

If you would like to participate in the TrueCare MSCAN Product and/or the TrueCare CHIP Product, you must be a MS Medicaid provider and OPT-IN by completing the information below.

If you need additional information, please email Don Foote at dfoote@mpcn-ms.com.

☐ **Yes, I would like to participate in TrueCare MSCAN.**

☐ **Yes, I would like to participate in TrueCare CHIP.**

Individual Mississippi Medicaid provider ID: _____

Office Hours for practice locations: _____

Nurse Practitioners, please list certification: _____

_____ (Practitioner Signature)

_____ (Print Name)

_____ (Date)

_____ (Tax ID)

_____ (Clinic/Group Name)

_____ (Group NPI)

_____ (Street Address)

_____ (City)

_____ (State)

_____ (Zip)

Please submit enrollment to Don Foote at:

Email: dfoote@mpcn-ms.com

OR FAX to Don Foote's attention: 601-605-4753.

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