Independent Living Systems, LLC

Standard Provider Agreement

Adult Family Care Home

____
Provider Name

Region ________________

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Part 1 - Cover and Signature Page

This agreement (the "Agreement") replaces any prior agreement, except for any prior agreement serving the Florida Long Term Care Community Diversion ("LTCCD") Waiver (aka Nursing Home Diversion Waiver), which LTCCD agreement will continue as the controlling agreement for the LTCCD until the Florida Statewide Medicaid Managed Care program replaces the LTCCD program in the subject counties. This Agreement has an effective date of ____________________ (the "Effective Date") and is by and between Independent Living Systems, L.L.C. (hereinafter referred to as "ILS" or "ILS Community Network" and ____, (hereinafter referred to as "Provider").

Provider shall provide, as an independent contractor, licensed Provider services for Enrollees in certain health care networks established or managed by ILS Community Network or a managed care plan ("Managed Care Plan"). This Agreement applies only to those contracts and to those Enrollees designated by ILS Community Network and includes enrollees in the State of Florida Programs and other Medicaid and Medicare plans or programs that may be identified in Part 5 - Programs, Rates, and Services or Part 6 – Participation Schedule(s). Provider represents and warrants that it is insured, licensed, certified and/or qualified and in good standing in accordance with the Mandates including but not limited to good standing with OIG, Medicaid, Medicare, and any other applicable regulatory authorities.

This Agreement includes this Part 1 - Cover and Signature, Page, Part 2 - Definitions, Part 3 - Terms and Provisions, Part 4 - Federal and State Regulatory Provisions, Part 5 - Programs, Rates, and Services, Part 6 - Participation Schedule(s) with Opt Out Required. By Executing Part 1 - Cover and Signature Page, Provider acknowledges receipt of this Agreement with each of these Parts. The State Mandates prevail in the event of conflict with other provisions in this Agreement.

ILS Community Network has contracted with one or more Managed Care Plans to provide services to those Managed Care Plans and/or Enrollees. Through this Agreement, ILS Community Network is contracting the provision of certain of such services to Provider. This Agreement provides the terms, rights and obligations of the parties hereto. In the event that (1) Managed Care Plan terminates its agreement between ILS and Managed Care Plan ("ILS/Managed Care Plan Agreement"); or (2) ILS terminates the ILS/Managed Care Plan Agreement, then Provider agrees to continue to participate with Managed Care Plan after the termination of the ILS/Managed Care Plan Agreement, so that for the purpose of serving Managed Care Plan's Enrollees, Managed Care Plan will assume the rights and obligations of ILS under this Agreement. Managed Care Plan and the Payor contracts applicable are listed in Part 6-Participation Schedules(s).

Remainder of this Page Intentionally Left Blank

IN WITNESS WHEREOF, each party hereto represents and warrants that it has taken all necessary action to authorize entering into this Agreement and that the person executing this Agreement has the authority necessary to bind the entity identified herein and have caused this Agreement with all its Parts to be executed. Any notices shall be provided to the persons and addresses listed below or at the Notice Section at 9.4 hereof.

Independent Living Systems, LLC

By:___________________________
Nestor Plana, CEO

Date___________________________

Provider: ___________________________

Print Name: ___________________________

Date ___________________________

Address: ___________________________

Tax ID #: ___________________________

Medicaid # ___________________________

NPI ___________________________

Medicare # ___________________________

Part 2 - Definitions

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

AFFILIATE - Any (i) corporation, partnership or other legal entity (including any Managed Care Plan) directly or indirectly owned or controlled by, or which owns or controls, or which is under common ownership or control with either party to this Agreement or (ii) person or entity, including but not limited to any contractor or subcontractor of a party, that is responsible for any part of a party's performance of its obligations under this Agreement.

ALLOWANCE - The Allowance shall be the pre-negotiated amount Provider agreed to accept for Covered Services under this Agreement for Enrollees enrolled in the (i) ILS Community Network or Managed Care Plan coverage plan for Preferred Provider Organization Benefit Program; (ii) ILS Community Network or Managed Care Plan for Point of Service Benefit Program, solely for the out-of-network component of such Benefit Program; or (iii) other Benefit Program, as ILS Community Network or Managed Care Plan may determine, at ILS Community Network or Managed Care Plan's sole discretion under the applicable ILS Community Network or Managed Care Plan coverage plan.

CARE MANAGER - A Managed Care Plan designated nurse, social worker, rehabilitation therapist, or other qualified individual who authorizes and oversees the provision of services to a Enrollee, including but not limited to the provision of Covered Services by a Participating Provider, including admission and discharge from facility providers.

CLEAN CLAIM - A claim that complies with the State requirements and Provider Handbook, if it is a paper claim, or the requirements of the HIPAA, if it is an electronic claim, that is received timely by Managed Care Plan or its delegee and has no defect, impropriety or lack of substantiating documentation from the Enrollee's medical or Provider records for Covered Services. It does not include a claim from a Provider who is under investigation for fraud or abuse, or a claim under review for medical necessity, pursuant to 42 CFR 447.45.

CO-INSURANCE - Upon satisfaction of the applicable deductible, the percentage of the Allowance not paid or payable by Managed Care Plan, which percentage is the responsibility of the Enrollee, and which is exclusive of all amounts due for deductibles, Co-Payments, benefit reductions, non-Covered Services and charges in excess of the allowance. The benefit payable by Managed Care Plan on behalf of a Enrollee under his/her Managed Care Plan coverage plan is the applicable percentage of the Allowance, subject to all deductibles, Co-Payments, Co-Insurance, penalties and other charges provided for in the applicable coverage plan.

CO-PAYMENTS - Charges pursuant to a ILS Community Network or Managed Care Plan coverage plan that are required to be paid by a Enrollee directly to Provider at the time Covered Services are rendered, in accordance with the schedule of benefits applicable to the particular ILS Community Network or Managed Care Plan coverage plan.

COVERED BENEFIT PLAN - an arrangement, contract or undertaking pursuant to which ILS Community Network or Managed Care Plan, any ILS Community Network or Managed Care Plan Affiliate or any Payer administers or arranges for the provision of Covered Services for Enrollees, including Products/Programs incorporated in this Agreement through modifications or Amendments, Medicare Advantage Plans, and Medicaid Plans.

COVERED SERVICES - Medically necessary medical, health care and support services to which a Enrollee is entitled to receive coverage under the terms and conditions of a Managed Care Plan.

CREDENTIALING AND RE-CREDENTIALING - the protocol for the process performed by ILS Community Network or its designee to verify that a Participating Provider satisfies ILS Community Network or Managed Care Plan's requirements for participation in its provider network, including, but not limited to licensure, certification, and any other requirements and/or standards adopted by ILS Community Network or Managed Care Plan regarding Participating Providers' qualifications. Credentialing criteria shall include protocols for the re-credentialing process of Participating Providers from time to time with such frequency as ILS Community Network or Plan's may elect.

ENCOUNTER DATA - Documentation provided to ILS Community Network or Plan by Provider on a monthly basis that summarizes all relevant information that pertains to any occasion where a Enrollee receives Covered Services, including all data necessary to characterize the context and purpose of each encounter between a Enrollee and a Participating Provider, supplier, physician or other practitioner, such as the Enrollee identification number, Provider identification number, date of service, applicable CPT and ICD codes, place of service and Provider's usual and customary charge for the service rendered. Encounter Data shall comply with applicable Accreditation Organization standards, laws and regulations in effect from time to time, and shall be on such forms and provided with such frequency as Mandates, ILS Community Network or Managed Care Plan may require.

ENROLLEE - Individual who meets the eligibility requirements under the applicable Payor Contract and is covered by or enrolled with a Managed Care Plan or program and is entitled to Covered Services offered by the Managed Care Plan or program.

GOVERNMENT SPONSOR - A State Regulatory Agency, Federal Regulatory Agency or other governmental entity authorized to offer, issue and/or administer one or more Programs, and which, to the extent applicable, has contracted with ILS Community Network or Managed Care Plan, or an entity with which ILS Community Network has contracted, to administer all or a portion of such programs.

HCBS - Home and community based services provided through multiple 1915(c) waivers.

ILS COMMUNITY NETWORK - is used in this Agreement as an alternative expression when referring to Independent Living Systems, LLC.

MANAGED LONG-TERM CARE ("MLTC") PROGRAM - Ongoing health and social services provided for individuals who need assistance on a continuing basis because of physical or mental disability. Services can be provided in an institution, the home, or the community, and include informal services provided by family or friends as well as formal services provided by professionals or agencies. This program is offered to individuals who qualify for an applicable State managed long term care program and who have enrolled in such a State managed long term care program.

MANDATES – All applicable State and Federal laws, rules, regulations, mandates and statements of policy in existence at all times hereunder, including, without limitation, applicable Medicaid laws, Medicare laws, rules, regulations and CMS requirements. The term "Mandates"

shall also include applicable Government contract requirements, Policies and Government Sponsor orders, directives, policies, mandates and requirements of any kind.

MEDICALLY NECESSARY OR MEDICAL NECESSITY - Medically Necessary or Medical Necessity means Covered Services provided in accordance with 42 C.F.R. Section 440.230 and as may be defined in State Mandates, to include those medical or allied care, good, or services furnished or ordered which:

(i) are necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;

(ii) are individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;

(iii) are consistent with the generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;

(iv) are reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available, statewide; and

(v) are furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

MEDICAID. An insurance program, funded jointly by the Federal and State governments and managed by the states, that provides medical coverage for low-income families and individuals, aged, blind or disabled individuals. Medicaid is provided for under Title XIX of the Social Security Act as amended.

MEDICARE - The Hospital Insurance Plan (Part A), the supplemental Medical Insurance Plan (Part B) and the Medicare Advantage Program (Part C) provided under Title XVIII of the Social Security Act, as amended. The health insurance program for people over 65 years of age, those eligible for Social Security disability payments, and those who need kidney dialysis or transplants.

PAYER - A domestic or foreign insurer, payer, employer, or other risk-bearing entity that entered into (i) a Payer Agreement and (ii) a Network Access Arrangement.

PLAN OF CARE - The written plan of care developed by Managed Care Plan, which includes but is not limited to a description of the Covered Services to be provided to a Enrollee. The Plan of Care shall include the amount, frequency and duration of Covered Services to be provided to the Enrollee. This written document is developed after an assessment has been conducted, that identifies the problems, goals, and interventions that will be implemented to attain the desired goals.

PROVIDER – a physician, health care facility, ancillary provider, or any other person or entity that has contracted with ILS Community Network and Managed Care Plan to provide Covered Services to Enrollees ("Participating Provider"), or that has not contracted with ILS Community Network and Managed Care Plan ("Non-participating Provider").

PROVIDER HANDBOOK - Manual containing ILS Community Network and applicable Managed Care Plan operating policies, standards, and procedures for Participating Providers which may include, but not limited to requirements for claims submission and payment, Credentialing, referrals, Utilization Management, case management, Quality Improvement, advance directives, provider complaints, and Enrollee rights, grievances and appeals.

QUALITY IMPROVEMENT PROCESSES - Processes of Managed Care Plan or ILS Community Network designed to ensure objectively the appropriateness and effectiveness of Covered Services rendered by Provider to Enrollees. Such processes include identifying deficiencies, implementing corrective action(s) to improve performance, and monitoring the corrective actions to ensure that quality of care has been enhanced.

SERVICE AREA - The area consisting of those counties, regions, or other geographic areas for which ILS Community Network or Managed Care Plan has Government Contract representing regulatory approval to provide services.

STATE - The States where Provider enjoys privileges to offer Provider services under this Agreement to Enrollees, ILS Community Network, and Managed Care Plan, as represented through any authorized agency, department, board, or commission.

URGENT CARE - Covered Services for conditions that (i) though not life-threatening, could result in serious injury or disability to the Enrollee unless medical attention is received or (ii) substantially restrict a Enrollee's activity; and (iii) which are provided (a) when a Enrollee is temporarily absent from the Service Area or; (b) under unusual and extraordinary circumstances, when the Enrollee is in the Service Area but all Participating Providers are temporarily unavailable or inaccessible when such Covered Services are Medically Necessary and immediately required (1) as a result of an unforeseen illness, injury, or condition; and (2) it was not reasonable given the circumstances to obtain the Covered Services through a Participating Provider. Examples include, without limitation, high fever, animal bites, fractures, severe pain, infectious illness, flu, and respiratory ailments.

UTILIZATION MANAGEMENT - Processes of Managed Care Plan or its delegee for determining the Medical Necessity of Covered Services designed to objectively ensure the appropriateness and effectiveness of Covered Services rendered by Provider to Enrollees.

UTILIZATION MANAGEMENT ("UM") PROGRAM - A comprehensive approach and planned activities for evaluating the appropriateness, need and efficiency of services, procedures and facilities according to established criteria or guidelines under the provisions of integrated care. Typically UM includes new activities or decisions based upon the analysis of a care, and describes proactive procedures, including discharge planning, concurrent planning, pre-certification and clinical case appeals. It also covers proactive processes, such as concurrent clinical reviews and peer reviews, as well as appeals introduced by the Provider, payer or Enrollee.

WELLNESS PROGRAMS - Comprehensive services designed to promote and maintain the good health of a Enrollee.

Part 3 - Terms and Provisions

ARTICLE I - Acronyms

Whenever used in this Agreement, the following acronyms will have the meanings identified below.

CMS: Centers for Medicare & Medicaid Services

CFR: Code of Federal Regulation

DHHS aka HHS: The United States Department of Health and Human Services

HIPAA: Health Insurance Portability and Accountability Act of 1996, as amended

ILS: Independent Living Systems - ILS Community Network

LTC: Long-term Care

NPI: National Provider Identification

OIG: Office of Inspector General

MFCU: Medicaid Fraud Control Unit, Office of Attorney General.

MPI: Medicaid Program Integrity, Office of Agency Inspector General

PR: Peer Review

QA: Quality Assurance

SNF: Skilled Nursing Facility

TPA: Third Party Administrator

ARTICLE II - Obligations of Provider

Government Program Representations.

ILS Community Network and/or its clients has or may seek one or more contracts to serve government programs Enrollees. Provider agrees, on behalf of itself and any subcontractors of Provider, to be bound by all rules and regulations of, and all requirements applicable to, such government programs. Provider acknowledges and agrees that all provisions of this Agreement shall apply equally to any employees and subcontractors of Provider who provide services to Enrollees of government programs, and Provider represents and warrants that Provider shall comply, and shall take all steps necessary to cause such employees and subcontractors to comply, with the terms of this Agreement and all Mandates, and perform all requirements applicable to government programs. With respect to Enrollees of government programs, Provider acknowledges that Managed Care Plan receives payments in whole or in part from federal funds, and Provider is subject to certain laws that are applicable to individuals and entities receiving federal funds. The parties acknowledge that while ILS Community Network and the Managed Care Plan have delegated the performance of certain services to Provider,

ILS Community Network and the Managed Care Plan remain responsible for the performance of the duties and services under the Managed Care Plan's agreement with the Government Sponsor. To confirm that all services are performed in accordance with this Agreement, Provider agrees to allow CMS, the Government Sponsor, any applicable State regulatory agency, ILS Community Network or the Managed Care Plan to monitor Provider's performance under this Agreement on an ongoing basis in accordance with Mandates and policies. Provider acknowledges and agrees that ILS Community Network and/or the Managed Care Plan may only delegate its activities and responsibilities under its contract(s) with the Government Sponsor and any applicable regulatory agency, to offer government program plans in a manner consistent with the Mandates , and that if any such activity or responsibility is delegated to Provider or a subcontractor, the activity or responsibility may be revoked if CMS, the Government Sponsor, ILS Community Network and/or the Managed Care Plan determine that Provider or subcontractor has not performed or is not performing satisfactorily.

2.1 Contract Election. Part 5 - Programs, Rates, and Services and Part 6-Participation Schedule attached hereto, and as amended, indicates the Managed Care Plan Contract and Payor Contract(s) under which Provider shall be a Participating Provider with ILS Community Network.

2.2 Provision of Services. The Provider agrees that services or goods billed to the Managed Care Plan and program must be medically necessary, of a quality comparable to those furnished by the Provider's peers, and within the parameters permitted by the Provider's license or certification. Provider shall render services to Enrollees in a manner that assures continuity of care. Provider shall comply with Managed Care Plan's cultural competency plan, as applicable and made available to Provider. Further, Provider agrees that services will be provided in a culturally competent manner to all enrollees, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds. All providers agreeing to participate in the network as Primary Care Physicians ("PCP") fully accept and agree to responsibilities and duties associated with the PCP designation.

2.3 Eligibility Verification. Provider agrees that it is responsible for verifying the eligibility of Enrollees prior to rendering Services through the means Managed Care Plan generally makes available to Participating Providers, whether electronic or otherwise.

2.4 Compliance with Policies. Provider agrees to comply with the Policies which are acknowledged as received, as modified from time to time, including those Policies contained in the Provider Handbook. The Provider Handbook and any modifications thereto are hereby incorporated by reference. Provider shall cooperate, participate and comply with Managed Care Plan's (or ILS Community Network's) Peer Review, grievance, the Minority Recruitment and Retention Plan, Quality Improvement, Utilization Management activities and appeals processes. Such activities include requirements that Provider: (i) obtain prior authorizations, and undergo concurrent review to ensure the Medical Necessity of services under the Managed Care Plan's Utilization Management program; and (ii) work in good faith to implement corrective actions the Managed Care Plan's Quality Improvement program initiates to improve the Service delivered to Enrollees. Provider shall provide for monitoring and oversight, including monitoring of services rendered to Enrollees, by the Managed Care Plan (or ILS Community Network), and identify the measures that will be used by the Managed Care Plan to monitor the quality and performance of the Provider. Provider will be notified in writing at least thirty (30) days prior to any modification of policies and/or the Provider Handbook by notifying Provider by electronic notification (email) and posting to ILS Community Network's website or other means. A shorter time may be required to comply with applicable Mandates. Provider shall provide a valid email address or

addresses for electronic notification to Provider of bulletins, changes to the Provider Handbook or this Agreement and other Notices that may be posted on ILS Community Network's website or other means of notification. The use of minority business enterprise providers is encouraged.

2.4.1 Provider may object to any such proposed modification to the polices during the thirty (30) day notice period in the event that Provider reasonably believes, and provides an explanation in support of the fact, that such proposed modification will have a material adverse financial impact upon Provider. At that time, the parties hereto will discuss in good faith a possible modification to the policies (taking into consideration each party's interpretation of the applicable Mandate(s) and the subject parties' concerns with regard to the modification. In the event the parties are unable to agree to any such modification to the policies within that thirty (30) day notice period, then either party may terminate this Agreement upon written notice to the other party, which effective date of termination shall be at least ninety (90) days following the receipt of such written notice of termination, unless terminated earlier in accordance with the terms of this Agreement. During the aforementioned ninety (90) day period, the subject policy shall remain in its original form and not be modified unless applicable Mandates expressly require the effectuation prior to such time.

2.5 Legal and Regulatory Compliance. Provider shall comply with the Mandates, including but not limited to, Payor Contract provisions, Managed Care Plan Contract provisions, policies, interpretations and instructions issued by Payors or Government Sponsors specifically relating to the delivery of Covered Services and the conduct of Provider's operations. Provider acknowledges that Managed Care Plan oversees and is accountable to Payors for any functions and responsibilities set forth in the Payor Contracts or applicable law.

The Provider shall comply with the laws of the State respecting advance directives, as such term may be defined in the State statues and/or regulations related to patient self-determination.

2.6 Licensure/Certification and Credentialing. Provider acknowledges that the Managed Care Plan and ILS Community Network must monitor and oversee Provider to assure proper credentialing. The Provider shall possess at the time of signing of the Agreement, and maintain in good standing throughout the period of the Agreement's effectiveness, a valid professional, occupational, facility or other license or certification or other authority qualifying the Provider to provide the Covered Services, as required by the Mandates, State or locality in which the Provider is located, and/or the Government Sponsor, if applicable. Provider shall notify ILS Community Network within five (5) business days in writing of: (i) any suspension, disenrollment, revocation, condition, expiration or other restriction of any licensure, certification or accreditation of Provider necessary to provide Covered Services; and (ii) the suspension or bar from, or imposition of any sanctions against Provider arising out of the provision of Covered Services provided pursuant to this Agreement. Failure to notify may result in sanctions imposed pursuant State statute and the Provider may be required to return funds paid to the Provider during the period of time that the Provider was suspended or disenrolled as a Medicare provider. Provider must notify ILS Community Network promptly upon Provider's knowledge of: (i) any investigative or disciplinary action initiated by any regulatory body against Provider arising out of the provision of Covered Services provided pursuant to this Agreement; (ii) the suspension, limitation, revocation or termination of Provider's hospital privileges; (iii) any adverse incident or action concerning or brought by a Enrollee against Provider; (iv) any litigation brought against Provider or any of its subcontractors or employees, that is related to the provision of Covered Services; (v) any employees or staff providing Covered Services pursuant to this Agreement being included on the List of Excluded Individuals and Entities; and

(vi) any settlement related to Covered Services provided under this Agreement or any of the foregoing or any other occurrence that could reasonably be expected to impair the ability of Provider to perform under this Agreement.

Provider must be eligible to participate in the Medicaid Program, Medicare Program (if applicable) and shall be subject to the Credentialing process identified in Provider Handbook or State Regulatory Standards prior to receiving status as a ILS Community Network, or Managed Care Plan, Participating Provider. If a Provider was voluntarily terminated from the Medicaid Program other than for purposes of inactivity, such Provider shall not be considered an eligible Provider. If the Managed Care Plan is capitated, all Providers must be eligible for participation in the Medicaid program; however, the Provider is not required to participate in the Medicaid program as a Provider. If the Managed Care Plan is Fee-For-Service ("FFS"), all health care subcontractors must be enrolled in the Medicaid program as a provider. If the Managed Care Plan is not Capitated, but rather Medicaid FFS, the Provider must also be enrolled in the Medicaid program as a provider. ILS Community Network shall perform credentialing and re-credentialing for its provider network pursuant to State and Federal requirements. Any Provider that ILS Community Network contracts with as part of this Agreement shall not sub-delegate services and/or credentialing without the prior written approval of the ILS Community Network.

Qualified residential Providers, such as licensed assisted living facilities and other residential care facilities, agree to comply with the home-like environment and the enrollee's community inclusion and integration as provided by the State by working with the managed care organization's case manager and enrollee to facilitate the enrollee's personal goals and community activities. All Providers shall comply with applicable Resident Bill of Rights and hereby confirms they are in compliance by execution of this Agreement.

2.7 Administrative Requirements.

2.7.1 Provider Availability. Provider agrees that it will accept new Enrollees for as long as it is accepting new patients enrolled in government sponsored programs subject to the scope of Provider's licensure or certification and any applicable Mandates and regulatory requirements including but not limited to provider-to-patient ratios. Provider shall provide at least sixty (60) days prior written notice to ILS Community Network if it or any of its locations are no longer available to prospective Enrollees.

2.7.2 Encounter Data and Reporting. Various State and Federal regulatory agencies require the Managed Care Plan to monitor and report on quality and utilization as a condition for accreditation and participation in the programs these agencies administer. In order to meet these obligations, Managed Care Plan must obtain information about clinical and ancillary encounters and Covered Services rendered to Enrollees by Provider ("Encounter Data") regardless of whether Provider must submit a claim for the provision of Covered Services. Provider is therefore, required to submit timely, complete and accurate Encounter Data to ILS Community Network and the Managed Care Plan in an electronic format pursuant to Section 4.2.1. hereof.

Facility and Home Health Providers shall use its best efforts to provide notice to the Managed Care Plan within 24 hours when an enrollee dies, leaves the facility, or moves to a new residence.

2.7.3 Electronic Claims. Provider shall prepare and submit to ILS Community Network or Managed Care Plan, according to the billing procedures established by ILS

Community Network and Managed Care Plan, billing information for Enrollees who have received Covered Services from Provider. Provider shall use its best efforts to submit its claims for Covered Services electronically: (1) If a capitated Managed Care Plan, then to the capitated Managed Care Plan for compensation; (2) If a FFS, MMA or LTC Plan, then to the Agency or its Agent, unless the service is a transportation service for which the Managed Care Plan receives a capitation payment from the Agency. For such capitated Covered Services or transportation services, the Managed Care Plan shall require providers to look solely to the Managed Care Plan for payment.

2.8 Plan of Care. The Care Manager will authorize and coordinate the provision of Covered Services rendered under this Agreement and as may be referenced in the Provider Handbook. Provider shall adhere to the Plan of Care established for Enrollees. Except in the case where a Enrollee's health or safety is in jeopardy, where such transfer to another Provider may be immediate, Provider shall refer and cooperate with the transfer of Enrollees for Covered Services only to Providers designated, specifically approved or under contract with ILS Community Network and Managed Care Plan. The Provider, in the event of a transitioning Enrollee, including in the event of the termination of this Agreement, shall cooperate in all respects with Providers of other Managed Care Plans to assure maximum health outcomes for Enrollees.

In the event that Provider renders a Enrollee non-covered services or refers a Enrollee to an out-of-network provider without pre-authorization from ILS Community Network or Managed Care Plan, Provider shall prior to the provision of such non-covered services or such out-of-network referral, inform the Enrollee in writing: (1) of the services to be provided or referral to be made; (2) that ILS Community Network and Managed Care Plan will not pay (or may pay a reduced benefit in the case of ILS Community Network and Managed Care Plan's point of service (POS) and/or preferred provider organization (PPO) products) or be liable financially for such non-covered service or out-of network referral and (3) that Enrollee will be responsible financially for non-covered service(s) and/or out-of-network referral(s) that are requested by the Enrollee. Provider acknowledges and agrees that the failure to inform Enrollee(s) in accordance with this paragraph may result in financial liability to Provider for the cost of such non-covered or non-authorized service(s). The Provisions of this Section shall not prohibit a Enrollee from receiving inpatient services in a contracted hospital if such services are determined by the Managed Care Plan to be medically necessary Covered Services.

This Agreement shall not prohibit a Provider from discussing treatment or non-treatment options with Enrollees that may not reflect the Managed Care Plan's position or may not be covered by the Managed Care Plan; and shall not prohibit a Provider from acting within the lawful scope of practice, from advising or advocating on behalf of a Enrollee for the Enrollee's health status, medical care, or treatment or non-treatment options, including any alternative treatments that might be self-administered; and shall not prohibit a Provider from advocating on behalf of the enrollee in any grievance system or UM process, or individual authorization process to obtain necessary services.

2.9 Hold Harmless. Provider agrees to comply with the following provisions:

(1) Provider hereby agrees that in no event, including but not limited to (i) non-payment by ILS Community Networks or Managed Care Plan, (ii) ILS Community Networks or Managed Care Plan's insolvency, or (iii) breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Government Sponsor, HHS, Enrollees, or persons

other than ILS Community Networks or Managed Care Plan acting on behalf of Enrollees for Covered Services provided pursuant to this Agreement. This provision is in addition to the protections afforded to Enrollee's under applicable law. This provision shall not prohibit collection from Enrollee of any non-covered service or Co-Payment amounts, cost sharing or patient responsibility in accordance with the terms of the applicable Enrollee's health care benefits contract and with the terms of this Agreement. In no event shall Medicaid recipients or any Government Sponsor be held liable for any debts or obligations of Provider.

(2) Provider agrees that in the event of ILS Community Network or Managed Care Plan's insolvency or other cessation of operations, benefits to Enrollees will continue through the period for which premium has been paid to Managed Care Plan by the State.

(3) In the event the agreement between Managed Care Plan and ILS Community Network is terminated by the applicable Government Sponsor, pursuant to the provisions of the applicable State statute, this Agreement shall be assignable on a prospective basis (without any obligation to pay any amounts owed to Provider by ILS Community Network) to Managed Care Plan for a period of time which is determined by the State to be necessary in order to provide the services that Managed Care Plan is legally obligated to deliver to its Enrollees. However, no such assignment shall exceed twelve months from the date the agreement between Managed Care Plan and ILS Community Network is terminated by the State.

ARTICLE III - ILS Community Network Obligations

3.1 Administration. Managed Care Plan or ILS Community Network functions and tools specific to Participating Providers under the Agreement include the following:

3.1.1 Payment. Managed Care Plan or its delegee will pay Provider for Covered Services in accordance with the services and rates set forth in Part 5 – Rates and Services, and within thirty (30) days of receipt of a Clean Claim or such shorter time period required by applicable law or Payor Contract.

3.1.2 Provider Handbook. ILS Community Network and/or Managed Care Plan will make the Provider Handbook available to Provider via website or other alternate means. Modifications or updates to the Provider Handbook shall be provided by ILS Community Network in accordance with Section 2.4 hereof. In the event of a conflict between this Agreement and the terms of the Provider Handbook, the terms of this Agreement shall control, note that however, the Provider Handbook may modify policies and operational procedures.

3.1.3 Provider Directory. ILS Community Network and Managed Care Plan shall be entitled to include Provider and its identifying information such as Provider's name, address, phone number, type of practice, office hours, languages spoken and hospital affiliation, in directories and listings of Participating Providers and other information they publish from time to time whether via posting to its website or other means.

3.1.4 Enrollee Eligibility. Managed Care Plan with which ILS Community Network has contracted will provide Enrollees with identification cards indicating their enrollment in a benefit agreement with Managed Care Plan. Enrollees' benefit agreements will

require them to present their identification cards when seeking Covered Services from Participating Providers. Managed Care Plan shall furnish Participating Providers with access to Enrollee eligibility information through electronic or other means. Managed Care Plan shall also provide assistance to Provider in identifying Enrollees eligible to receive Covered Services. As Payors may retroactively disenroll individuals, Enrollee eligibility status is subject to change retroactively. In the event of such retroactive disenrollment, and if the Managed Care Plan has authorized Covered Services, Managed Care Plan shall be responsible for payments to Provider and shall not be permitted to recover payments made to Provider by Managed Care Plan for Covered Services rendered on or after the date of an individual's ineligibility. Provider may obtain payment directly from certain other responsible third parties for Covered Services other than authorized by the Managed Care Plan or services which are not included in the Medicaid Program as Covered Services.

ARTICLE IV - Compensation

4.1 Compensation. Provider shall accept as payment in full for the provision of Covered Services to Enrollees, reimbursement at the rates set forth in Part 5-Programs, Rates, and services less any applicable Enrollee Co-payments, deductibles, Co-insurance, and/or cost-share amounts required directly from the Enrollee, and shall not waive, discount or rebate any such amounts due. Residential facility Providers may collect any patient responsibility that may be applicable on behalf of Managed Care Plan and are prohibited from the assessment of late fees to the Enrollees. The Provider shall look solely to the Managed Care Plan for compensation for services rendered, and shall not seek additional payment from a Enrollee for any Covered Services, with the exception of permitted nominal cost sharing and patient responsibility, pursuant to the Medicaid State Managed Care Plan and the Medicaid Provider General and Coverage and Limitations Handbooks. Provider hereby assigns to ILS Community Network or Managed Care Plan all Provider's recovery, reimbursement or subrogation rights along with other benefits that may be payable with respect to a Enrollee. Managed Care Plan contractor will assume full responsibility for cost avoidance measures for third party collections in accordance with the Mandates. Payments will be made by Managed Care Plan pursuant to State Statutes or other Mandates that may apply to Managed Care Plan, including, but not limited to 42 CFR 447.46, 42 CFR 447.45 (d)(2,3,5 and 6) and Section 1.10 Third Party Resources, or subsequent section numbers applicable, in the Government Contact with Managed Care Plan. Provider shall make no payment to a physician under a physician incentive plan unless such incentive plan complies with 42 CFR 417.479. This includes that no specific payment directly or indirectly will be made as an inducement to reduce or limit medically necessary services to an enrollee and all physician incentive plans do not provide incentives, monetary or otherwise, for the withholding of medically necessary care.

4.1.1 Provider agrees to notify ILS Community Network in writing of the date and amount of any increase in its usual and customary charges no later than the effective date of the increase if reimbursement under this Agreement is based on a percentage discount off of usual and customary rates. If a Provider paid on a fee for service basis implements a rate increase for its usual and customary charges, the Provider agrees to discount the new rates to ILS Community Network and Managed Care Plan so that no higher payment shall be paid by ILS Community Network or Managed Care Plan than it would have paid had such rate increase not taken place. The Provider must not charge for any service provided to the recipient at a rate in excess of the rates established by this Agreement with the Provider in accordance with Section 1128B(d)(1), Social Security Act (enacted by Section 4704 of the Balanced Budget Act of 1997).

4.1.2 Medicaid Pending applicants will need an agreement with Provider for payment according to applicable State standards. If an individual's Medicaid eligibility is denied following a Medicaid Pending referral or Medicaid Pending status, the individual may not be referred for enrollment and/or continue to receive Managed Care Plan authorized Covered Services until their Medicaid financial eligibility is approved. If the individual is denied eligibility by the State, then is subsequently approved for Medicaid with a retroactive eligibility date for previously ineligible months, the Managed Care Plan may not seek reimbursement for ineligible months, however the Managed Care Plan will not compensate Provider for services not authorized by the Managed Care Plan. Managed Care Plan shall not retrospectively deny previously authorized services. The Provider may not seek payment from a Medicaid Pending enrollee on behalf of the Managed Care Plan.

4.2 Billing. Provider shall bill Managed Care Plan or its delegee, as applicable, for Covered Services rendered to Enrollees within sixty (60) days of the date(s) on which Covered Services were rendered by Provider except as such time frame may be modified by Mandates or reflected in the State Exhibit/Addenda hereto. The Provider further agrees to bill only for the services performed within the scope of license and specialties designated in Part 5-Programs, Rates, and Services. The services or goods must have been actually provided to eligible recipients by the Provider prior to submitting the claim. In the case of an acute and/or sub-acute admission the date of Provider agrees to submit all claims eligible for reimbursement as provided under this Agreement within sixty (60) days from the date of discharge except as such time frame may be modified by Mandates or reflected in the State Exhibit/Addenda hereto. If Provider has not billed Managed Care Plan or its delegee within the time frame required above, Provider's claim for payment of such bills may be deemed waived and no payment shall be made by Managed Care Plan or its delegee unless Managed Care Plan is not the primary payer. Provider shall submit claims to Managed Care Plan or its delegee electronically in a format that complies with the transaction and code set standards established by the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (collectively "HIPAA").

4.2.1 Provider is required to submit timely, complete and accurate Encounter Data to ILS Community Network, or if so directed to the Managed Care Plan, in an electronic format designated by the Provider Handbook (e.g. a CMS 1500, UB04, 837p, 837i, or other format identified) for the provision of all Covered Services to Enrollees for which it is submitting a claim. Claims not submitted via the defined electronic and paper formats outlines are subject to rejection.

4.2.2 Payments will be made by Managed Care Plan pursuant to applicable section(s) of State Statutes or other regulatory sections that may apply to Managed Care Plan, including, but not limited to 42 CFR 447.46, 42 CFR 447.45 (d)(2,3,5 and 6) and the applicable section on Third Party Resources in any Government Contact with Managed Care Plan.

4.2.3 Adjustments. To the extent Provider disputes payments made by Managed Care Plan or its delegee, it shall notify Managed Care Plan or its delegee, as applicable in writing within sixty (60) days of receipt of payment or such shorter time frame required by applicable law or Payor Contract. Unless Provider disputes Managed Care Plan's or its delegee's payment within the time frame indicated above, prior payment of the disputed claim(s) shall be considered final payment in full and will not be further reviewed by Managed Care Plan or its delegee. Provider shall also promptly report and

return to Managed Care Plan or its delegee any funds received in error or in excess of the amount to which Provider is entitled within sixty (60) days of identifying the overpayment or of which Managed Care Plan or its delegee notifies Provider. Upon thirty (30) days prior written notice to Provider and in accordance with applicable law and Payor Contract, Managed Care Plan or its delegee may recover any overpayments made to Provider or other obligations of Provider owed to Managed Care Plan or its delegee by offsetting them against payments due Provider from Managed Care Plan or its delegee.

4.3 Coordination of Benefits. ILS Community Network or Managed Care Plan will coordinate benefits in accordance with Mandates and in accordance with its health care benefit contracts. Provider shall cooperate with Managed Care Plan or its delegee so as to allow Managed Care Plan to evaluate possible subrogation claims and properly coordinate benefits in accordance with the requirements of applicable laws and coordination of benefit guidelines. Provider agrees to bill other payor(s) with the primary liability *(including the Medicare program, if the recipient is eligible for payment for health care or related services from another insurer or person and comply with all other State and Federal requirements in this regard)* prior to submitting bills for the same services to Managed Care Plan or its delegee. Provider also agrees to provide Managed Care Plan or its delegee with relevant information it has collected from Enrollees regarding coordination of benefits. If Managed Care Plan is not Enrollee's primary payor, Provider's compensation by Managed Care Plan or its delegee shall be no more than the difference between the amount paid by the primary payor(s) and the applicable rate under this Agreement, less any applicable Co-payments or Co-insurance.

4.3.1 Provider payment will not be delayed due to ILS Community Network or Managed Care Plan recovery efforts from Third Parties. In cases where a Enrollee has coverage, other than with ILS Community Network or Managed Care Plan, which requires or permits coordination of benefits from a third party payor in addition to ILS Community Network or Managed Care Plan, ILS Community Network or Managed Care Plan will coordinate its benefits with such other payor(s). ILS Community Network or Managed Care Plan will pay the lesser of (i) the amount due under this Agreement, or (ii) the amount due under this Agreement less the amount payable or to be paid by the other payor(s), or (iii) the difference between allowed billed charges and the amount paid by the other payor(s). In the event Medicare is the primary payor, ILS Community Network or Managed Care Plan shall pay Provider the amount of deductible, Co-Insurance and/or other plan benefits which are not Covered Services under Title XVIII of the Social Security Act, as amended, subject to the benefit limits and applicable rates of the applicable health care benefits contract. In no event will ILS Community Network or Managed Care Plan pay a monetary amount which when combined with payments from the other payor(s) exceeds the contracted rate provided in this Agreement.

4.4 ILS Community Network as Agent for Provider. ILS Community Network may act as agent for Provider with regard to the payment of claims by Managed Care Plan or its delegee, and in such capacity as agent may assist Provider in resolving any claims adjudication issues that Provider may have with Managed Care Plan or its delegee.

4.5 Compensation Changes due to Changes in Government Contract. During the term of this Agreement, changes may occur in the compensation paid to Providers. This may occur due to a variety of reasons, including but not limited to, changes mandated by the Government sponsor, the Managed Care Plan, an amendment, modification or change to the Government Contract or an additional or new Program or Managed Care Plan being added to Part 6,

Program Participation Schedule of this Agreement. ILS Community Network and Managed Care Plan agree to provide thirty (30) days written notice prior to the implementation of such new payment amounts and, unless Provider notifies ILS Community Network in writing within 15 days of such notice that Provider declines to accept such change, the change will be effective as of its announced implementation date. In the event Provider provides to ILS Community Network such notice, ILS Community Network and Provider shall discuss and agree on appropriate alternatives to the new payment amounts, including but not limited to Provider not providing certain Provider Services. In the event no notice is possible due to an immediate change mandated by the Government sponsor, Provider upon sixty (60) days prior written notice to ILS Community Network may decline to accept such change.

4.6 Itemized Payment Disclosure. Claims payment to a Provider an itemized accounting of the individual claims included in the payment including, but not limited to, the Enrollee's name, the date of service, the procedure code, the service units, the amount of reimbursement, and the identification of the Managed Care Plan.

ARTICLE V - Records and Audits

5.1 Maintenance of Records. Provider agrees (a) to maintain an adequate record system to maintain Information and Records (as such terms are defined in Mandates, Policies or herein) in a current, detailed, organized and comprehensive manner including but not limited to Records relating to the services, charges, dates and other commonly accepted information elements for the services rendered to the Managed Care Plan, in accordance with customary practice, applicable Mandates, Federal and State laws, and accreditation standards; (b) that all Enrollee health and medical records shall be treated as confidential and in accordance with applicable laws; (c) to maintain such Information and Records for ten (10) years after the termination or expiration date of this Agreement, or such other period required for the completion of any review or audits, Mandates, applicable laws, rules or regulations, or as reflected in the State Exhibit/Addenda attached hereto. This will include documentation of written notice to the Managed Care Plan within 24 hours when an enrollee dies, leaves a Provider facility or moves to a new residence. This Section shall survive the termination of this Agreement, regardless of the cause of the termination.

> ***5.1.1*** Prior approval for the disposition of records subject to audit must be requested and approved by the State or Federal authority as applicable. Prior approval for the disposition of records must also be requested and approved by the Managed Care Plan if this Agreement is continuous.
>
> ***5.1.2*** Providers that are assisted living facilities and nursing facilities shall keep a copy of the Plan of Care on file in the Enrollees record and available for inspection by Managed Care Plan, ILS Community Network, the appropriate State representatives and Government Sponsor. A copy of the Plan of Care will be forwarded to the facility by ILS Community Network or Managed Care Plan within ten (10) days of development.

5.2 Access to Information and Records. Provider agrees that (a) it will forward all pertinent information relating to the health care of Enrollees to Enrollees' primary care provider and, as required, to Managed Care Plan in a timely fashion; (b) ILS Community Network, Managed Care Plan any Federal or State regulatory authority, or any designee shall have timely access, during normal business hours, on at least twenty-four (24) hours advance notice, or such shorter notice as may be imposed on ILS Community Network or Managed Care Plan by a Federal or State regulatory agency or accreditation organization, to all data and information

obtained, created or collected by Provider, or any Affiliates, related to Enrollees relevant to this Agreement and necessary for payment of claims; (c) ILS Community Network and Managed Care Plan (including ILS Community Network and Managed Care Plan's authorized designee) and Federal, state, and local Government Sponsor and their agents having jurisdiction, including but not limited to DHHS, State Medicaid Agency, MPI and MFCU, upon request, shall have the right to inspect, review, make copies, evaluate and audit all of the following related to this Agreement, all pertinent books, financial records, medical/case records, and other documents, papers and records (including, but not limited to, contracts and medical and financial records) and information relating to this Agreement and to those services rendered by Provider to Enrollees ("Records"); (d) consistent with the consents and authorizations required by this Agreement, ILS Community Network and Managed Care Plan or its agents or designees shall have access to Enrollee Records for the purpose of assessing quality of services, conducting audits, and, where applicable, performing utilization management functions; (e) applicable Federal and State authorities and their agents shall have access to any Records pertinent to the Government Sponsored program contract and for assessing the quality, appropriateness and timeliness of services or investigating Enrollee grievances or complaints; and (f) where applicable, Enrollees shall have access to their health information as required by 45 C.F.R. § 164.524 and applicable State law, be provided with an accounting of disclosures of information when and as required by 45 C.F.R. § 164.528 and applicable State law, and have the opportunity to amend or correct the information as required by 45 C.F.R. § 164.526 and applicable State law. Provider agrees to supply copies of information and Records within fourteen (14) days of the receipt of a request, where practicable, and in no event later than the date required by any Mandate or regulatory authority. Copies of such records shall be at no additional cost to ILS Community Network or Managed Care Plan or the Enrollee. Copies provided to third parties shall be provided at Provider cost unless the copies are needed in connection with Provider related issues, in which case, the copies shall be free of charge. This Section shall survive the termination of this Agreement, regardless of the cause of termination.

5.2.1 Upon request from ILS Community Network or Managed Care Plan or a Enrollee, Provider shall transfer the complete original or a complete acceptable copy of the medical records of any Enrollee transferred to another Provider and/or medical facility for any reason, including termination of this Agreement. The transfer of medical records shall be at no additional cost to ILS Community Network or Managed Care Plan or the Enrollee and shall be within a reasonable time following the request but in no event less than five (5) business days except in cases of emergency. Provider agrees that such timely transfer of medical records is necessary to ensure the continuity of care for Enrollees.

5.3 HIPAA Compliance. Provider and ILS Community Network shall abide by HIPAA and all other Federal and State laws regarding confidentiality and disclosure of medical records and other health and Enrollee information including safeguarding the privacy and confidentiality of any health information that identifies a particular Enrollee. Provider shall assure its own compliance and that of its business associates with all privacy, security and administrative simplification provisions of HIPAA. Compliance with HIPAA privacy and security provisions, include 45 CFR, Part 160 & 164 and safeguarding of information about enrollees in accordance with 42 CFR, 438.224 and 42 CFR, Part 431, Subpart F as applicable. Provider shall cooperate with Managed Care Plan to document compliance certification (business-to-business) testing of transaction compliance with HIPAA for any Provider receiving enrollee data.

5.4 Cooperation. Provider shall fully cooperate with any inquiries or investigations or any subsequent legal action that may result from such investigation by any Government Sponsor or government agency, including MPI, MFCU, the Agency or other State or Federal entity.

ARTICLE VI - Insurance and Indemnification

6.1 Insurance. Provider shall, at all times during the term of the Agreement, secure and maintain workers' compensation insurance (complying with the state's worker compensation law) for all of its employees connected with the work under this Agreement unless such employees are covered by the protection afforded by the Managed Care Plan, as well as general liability insurance, and professional/malpractice insurance coverage for all of his/her/its employees connected with services provided to ILS Community Network or Managed Care Plan pursuant to and in compliance with Mandates. Prior to execution of this Agreement and upon request at any time during the term of the Agreement, Provider shall provide to ILS Community Network evidence of such insurance coverage according to credentialing verification standards. Provider shall notify ILS Community Network and Managed Care Plan promptly if it receives notification of a lapse of any such insurance coverages, or if its assets or such other financial benchmark falls below the amount necessary for licensure under State Statute.

> ***6.1.1*** Without waiving the right to sovereign immunity as may be provided in Mandates, the Provider may acknowledge by attestation it is self-insured for general liability under a State's sovereign immunity statute with monetary waiver limits per person and per occurrence, as such limits may be changed and set forth by State law. Provider agrees to notify ILS Community Network if, during the term of this Agreement, any change occurs regarding Provider's entitlement to sovereign immunity.

6.2 Relationship of the Parties; Indemnification. The relationship between ILS Community Network, Managed Care Plan, and Provider, as well as their respective employees and agents, is that of independent contractors, solely for the purposes of carrying out the terms of this Agreement, and except as otherwise provided herein, neither shall be considered an agent or representative of the other party for any purpose, nor shall either hold itself out to be an agent or representative of the other for any purpose. The parties hereby agree to indemnify and hold each other harmless, including any Affiliates, officers, employees and agents, against any loss, liability, damage, costs and expenses (including any attorneys' fees) suffered or incurred by the other in connection with any (including any threatened or proposed) action, suit, proceeding, regulatory proceeding, demand, assessment or judgment arising out of or related to the indemnifying party's and/or the indemnifying party's Affiliates and agents acts and/or omissions in the performance of a party's respective obligations under this Agreement. If each party claims and is entitled to indemnity from the other, the liability of each to the other shall be their amount of comparative fault. This provision shall survive the expiration or termination of this Agreement, regardless of the reason for termination. Procedures for indemnification are as set forth in the Provider Handbook.

6.3 Penalties. Provider is responsible for any and all penalties that the Government Sponsor may assess against Managed Care Plan or ILS Community Network that arise due to Provider's failure to provide or delay in providing Covered Services for which Provider has agreed to provide to Enrollees. Managed Care Plan or ILS Community Network reserves the right to assess penalties equal to those penalties that the Government Sponsor may assess against Managed Care Plan or ILS Community Network. The right to pass through such penalties to Provider is subject to Provider's due process rights similar to that which is provided Managed Care Plan under its contract with the Government Sponsored program.

ARTICLE VII - Term and Termination

7.1 Term. This Agreement shall become effective as of the Effective Date and shall continue in effect for a period of one (1) year. Thereafter, the Agreement shall automatically renew for additional periods of one (1) year, unless terminated in accordance with Section 7.2 below. ILS Community Network or Managed Care Plan shall give Provider sixty (60) days written notice of any decision not to renew this Agreement unless a longer time period is required by Mandates. Provider also acknowledges that the Effective Date of this Agreement is dependent upon Managed Care Plan's or ILS Community Network's credentialing of Provider. Therefore, once Managed Care Plan or ILS Community Network has credentialed Provider, ILS Community Network will countersign this Agreement, complete the blank portions on the first page indicating the Effective Date, and return a countersigned original to Provider.

7.1.1 Participation Schedule effective dates.
The effective date of any Participation Schedule shall be the Effective Date of the Agreement if the Participation Schedule is executed prior to the Agreement Effective Date. Thereafter, the Participation Schedule is effective as dated with consideration to Managed Care Plan or Program Credentialing requirements and ILS Community Network protocols. Termination of a Participation Schedule or removal of a Managed Care Plan or Program does not terminate the Agreement between ILS Community Network and Provider.

7.1.2 Location effective dates.
A particular Provider location associated with this Agreement may be added or terminated, with this Agreement remaining in full force and effect with respect to other Provider locations that may be identified herein and are not terminated. The Effective Dates for such Locations will be as acknowledged and at the sole discretion of ILS Community Network.

7.2 Termination. This Agreement may be terminated by the mutual consent of ILS Community Network and the Provider at any time subject to compliance with Mandates or as reflected in the State Exhibit/Addenda hereto and otherwise as follows:

(a) Except as provided in Subsection 7.2(b), ILS Community Network may terminate this Agreement for any reason effective ninety (90) days following written notice to Provider of such termination. Such written notice shall include the following:

(i) the circumstances relating to the termination; and

(ii) if Provider is an individual physician or provider, notice that Provider has the right to request a hearing or review, at Provider's discretion, before a panel appointed by ILS Community Network and a time limit of not less than thirty (30) days within which Provider may request a hearing.

(b) ILS Community Network or Managed Care Plan may terminate this Agreement, or the Participation Schedule, effective immediately if ILS Community Network or Managed Care Plan determines in good faith that: (i) Provider's actions or proposed actions threaten imminent harm to patient care (in which case the patient may be immediately transferred to a new Provider), (ii) Provider has engaged in fraud, or (iii) a

final disciplinary action has been taken by a State licensing board or other governmental agency which impairs Provider's ability to practice.

(c) Provider may terminate this Agreement or the Participation Schedule upon at least ninety (90) calendar days written notice to ILS Community Network before the effective date of withdrawal.

(d) By written notice to Provider, ILS Community Network or Managed Care Plan's medical director may suspend referrals or assignments of Enrollees to Provider if Managed Care Plan determines Provider is not complying with (1) the terms of this Agreement, (2) Managed Care Plan's policies and procedures, or (3) Managed Care Plan's requirements for credentialing or re-credentialing.

(e) Notwithstanding any termination instituted by ILS Community Network or Managed Care Plan pursuant to the terms of this Agreement, ILS Community Network or Managed Care Plan shall retain all rights to damages. The rights of termination referred to in this Agreement are not intended to be exclusive and are in addition to any other right or remedies available by law.

(f) In addition to any other right to terminate this Agreement, and notwithstanding any other provision of this Agreement, the State may request immediate termination of this Agreement if, as determined by the State, a Provider fails to abide by the terms and conditions of the Agreement, or in the sole discretion of the State, the Provider fails to cure any breach of the terms of, or to come into compliance with the Agreement within 15 calendar days after receipt of notice from the ILS Community Network or Managed Care Plan, specifying such breach or noncompliance and demanding such Provider abide by the terms and conditions thereof. Any Provider whose participation is terminated pursuant to this Section 7.2 for any reason may utilize the applicable appeals procedures, if any, in the Provider Handbook or related Bulletin.

(g) ILS Community Network or Managed Care Plan may revoke delegation, or impose other sanctions, if the Provider's performance is inadequate.

7.3 Other Entities. If Provider is a corporation, professional association, partnership, or other entity ILS Community Network may in its sole discretion exclude any officer or employee of such corporation, association or partnership from providing services under this Agreement. Such exclusion shall not be construed as a termination of this Agreement.

7.4 Obligations upon Termination. Upon termination of this Agreement, the rights of each party hereunder shall terminate, provided however, that such action shall not release Provider or ILS Community Network and Managed Care Plan of their obligations with respect to: (i) payments accrued to Provider, as applicable, prior to termination; (ii) Provider's agreement not to seek compensation from Enrollees for Covered Service provided prior to termination or pursuant to subsection (iii) below; and (iii) the continuation of Provider's obligations with respect to, and Provider's continuity of treatment and care for, Enrollees as provided in this Agreement. ILS Community Network or Managed Care Plan shall compensate Provider for such care pursuant to the terms of this Agreement. Provider further agrees that: (a) this provision shall survive the termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of Enrollee and ILS Community Network or Managed Care Plan, as applicable. Upon notice of termination, Provider shall cooperate in all respects with ILS Community Network and Managed Care Plan, applicable Policies and Managed Care

Plan protocols, if any, in the transitioning of Enrollees, and the continuity of treatment, to other Providers or providers of another Managed Care Plan, to assure maximum health outcomes for Enrollees.

ARTICLE VIII - Dispute Resolution

8.1 Provider Grievance Dispute Resolution. Provider agrees to (a) cooperate with and participate in ILS Community Network and Managed Care Plan's applicable appeal, grievance and external review procedures (including, but not limited to, Government Program appeals and expedited appeals procedures), (b) provide ILS Community Network and Managed Care Plan with the information necessary to resolve same, and (c) abide by decisions of the applicable appeals, grievance and review committees.

8.2 Dispute Resolution. The parties shall attempt in good faith to resolve any dispute arising out of or relating to this Agreement promptly by negotiation between executives who have authority to settle the controversy. If such dispute is not resolved in the normal course of business, then the parties may mutually agree to institute arbitration proceedings on such terms to be mutually agreed or a party may take such other action as it deems necessary.

ARTICLE IX - Miscellaneous

9.1 Provider-Member Relationship. The parties agree that Provider shall maintain a traditional provider-patient relationship with Managed Care Plan's Enrollees. Provider shall be solely responsible to the Enrollee for the provision of Covered Services. Provider may freely communicate with, advocate for, and advise Enrollee accordingly, regarding the diagnosis of Enrollee's condition, care and available treatment regardless of whether any treatments are Covered Services or reflect ILS Community Network's or Managed Care Plan's position. Nothing in this Agreement is intended to interfere with Provider's patient relationship with Managed Care Plan Enrollees.

9.2 Third Party Beneficiaries. Except as specifically provided herein, the terms and conditions of this Agreement shall be for the sole and exclusive benefit of the Provider and ILS Community Network and their client Managed Care Plans. Nothing herein, express or implied, is intended to be construed or deemed to create any rights or remedies in any third party.

9.3 Provider, Employee and Independent Contractor Compliance. All of the terms of this Agreement, unless clearly inapplicable, shall apply to all employees and independent contractors who provide services to Enrollees on Provider's behalf. Any Provider that ILS Community Network contracts with may not sub-delegate services and/or credentialing without the written approval of ILS Community Network. Provider agrees that it is its responsibility to assure the compliance of such individuals with the terms and conditions of this Agreement that are applicable to them including compliance with applicable laws, regulations, Policies, Payor instructions, Payor Contract and Managed Care Plan Contract provisions. Provider shall take all steps necessary to assure such compliance including requiring such individuals by contract to abide by the above requirements. Provider shall provide ILS Community Network and Managed Care Plan with copies of its contracts with such individuals which may be redacted to exclude fees paid to such individuals as Managed Care Plan may require. Provider shall not employ nor subcontract with individuals on the State or Federal exclusions list. Provider shall ensure direct service representatives complete applicable abuse, neglect and exploitation training. Providers are subject to background checks. The Payor Contract, Mandates, and the nature of the work a subcontractor or Provider performs will determine the level and scope of

the background checks. The Provider Handbook or Bulletins will reflect such requirements which will typically be in line with Provider license or certification requirements.

9.4 Notices. Any notice required or permitted to be given under this Agreement shall be in writing and shall be delivered (I) in person, (ii) by certified mail, postage pre-paid, return receipt requested, (iii) on the date of transmission by facsimile, (iv) by commercial courier that guarantees delivery and provides a receipt, or (v) verification of Provider pickup at a Provider internet portal. Any notice shall be effective only upon delivery, which for any notice given by facsimile, shall mean notice that has been received by the party to whom it is sent as evidenced by confirmation of transmission by the sender. Such notices to Provider shall be addressed as shown on Part 1-Cover and Signature page unless changed in conformity with this section 9.5. Additional Notices address, if any, follows:

Additional Provider Notice Address (complete if any)

____
____
____
Attn: ______________________
Facsimile #: _______________

Notice to ILS Community Network shall be:

____
____
____
Attn: ______________________
Facsimile #: _______________

Either party may from time to time specify in writing to the other party a change in address for purposes of notice hereunder.

9.5 Agreements, Amendment. This Agreement constitutes the entire understanding of the Parties hereto and no changes, amendments or alterations shall be effective unless signed by both Parties, except as expressly provided in Section 9.6 herein. Except for Amendments to Part 6-Participation Schedule, all amendments to this Agreement must be made in writing and with the consent of both parties. For Amendments to Part 6-Participation Schedule that add one or more Managed Care Plans or Programs, the ILS Community Network shall notify Provider in writing with at least 30 days' notice of the effective date of such an Amendment. Unless Provider objects in writing within the 30 days, such Amendment will become effective as of the proposed effective date. For Amendments to Part 6-Participation Schedule that delete (terminate) one or more Managed Care Plans, ILS Community Network will notify Provider in writing with notice of such an Amendment Termination according to Article VII-Term and Termination. ILS Community Network and Provider will be subject to all continuation of service obligations that relate to a contract termination for Enrollees of Managed Care Plans that are to be terminated. Contract will remain in force for all Managed Care Plans that are not to be terminated.

Notwithstanding the above, this Agreement may, upon at least thirty (30) days' advance written notice (unless a shorter period is required by Mandate) from ILS Community Network or the Managed Care Plan be automatically amended to comply with the Mandates and requirements of State or Federal law or regulation and any Payor Contract(s). In the event that Provider reasonably believes such amendment is likely to have a material adverse financial impact upon

Provider, Provider agrees to notify ILS Community Network, during that thirty (30) day notice period, specifying the specific bases demonstrating a likely material adverse financial impact. Thereafter, the Parties will attempt to negotiate in good faith an appropriate additional amendment to this Agreement. Pending negotiation, the terms of this Agreement shall remain in their original form and not be amended unless any such regulatory agency and/or accreditation body expressly directs (either in direct response to an inquiry from either party to this Agreement or by any other means) the effectuation of such amendment sooner. Any material amendment to this Agreement may require the prior written approval of the State, to whom any such material amendment shall be submitted for approval, according to any Mandates, in advance of amendment or anticipated execution by parties.

9.6 Assignment. This Agreement is intended to secure the provision of services by Provider and shall not be assigned, delegated or transferred by Provider whether by merger, sale of more than 33% of the stock or other ownership interest, or by operation of law without the prior written consent of ILS Community Network. This Agreement may be assigned and/or certain rights and obligations delegated by ILS Community Network to any Affiliate or successor to the business of ILS Community Network or any Managed Care Plan with which Provider has an active Participation Schedule, or to the Government Sponsor with thirty (30) days written notice to Provider.

9.7 ILS Community Network Information. Provider agrees that all records, reports, data, financial information, including the rates of compensation hereunder and any other non-publicly available information given or transmitted to it by ILS Community Network are the confidential and proprietary information of ILS Community Network, and constitute its trade secrets. Provider agrees not to disclose such information to any person or entity except to Provider's accountants, attorneys or other authorized representatives or as required for Provider's performance of its obligations under this Agreement or by law. Provider also agrees that it will not use Managed Care Plan Enrollee lists, mailing lists or any such proprietary or confidential information ILS Community Network has provided to Provider to encourage, counsel or otherwise advise Enrollee(s) to disenroll from Managed Care Plan with which ILS Community Network has contracted and enroll in a competing health plan. Additionally, Provider shall not use the name or marks of ILS Community Network or Managed Care Plan in any communication without obtaining the prior written approval of ILS Community Network for such communications. In the event of a violation or threatened violation of this Section, ILS Community Network is entitled to seek all available remedies at law or equity including an injunction enjoining and restraining Provider from violating this Section. This Section 9.7 shall survive the termination of this Agreement for one (1) year, regardless of the cause of termination.

9.8 Severability. If any term or provision of this Agreement is held to be invalid or unenforceable, the remainder of the provisions shall not be in any way affected, but shall remain in full force and effect.

9.9 Waiver. The waiver by either Party of a breach, violation or noncompliance of any provision of this Agreement shall not operate as or be construed to be a waiver of any subsequent breach thereof. To be effective, all waivers must be in writing and signed by an authorized officer of the Party to be charged.

9.10 Governing Law. This Agreement shall be construed and enforced in accordance with the laws of the State of Florida. Any legal action permitted under this Agreement shall be in the State or Federal Courts of the State of Florida.

9.11 Inconsistency. In the event of any provision of this Agreement is not permissible under applicable law or the Payor Contract(s) or Managed Care Plan Contract(s), the applicable law will control, or in the absence of applicable law, the applicable Payor Contract(s) or Managed Care Plan Contract(s) shall control.

9.12 Counterparts, Captions, and Headings. This Agreement may be executed in separate counterparts, each of which shall be deemed an original, but both of which together shall constitute one and the same instrument. This Agreement shall become binding when one or both counterparts hereof, individually or taken together, shall bear the signatures of the Parties. The captions or headings contained in this Agreement are included for purposes of convenience only, and shall not affect in any way the meaning or interpretation of any of the terms or provisions of this Agreement.

9.13 Entire Agreement. This Agreement including all Parts listed below, exhibits, attachments and amendments hereto, and the documents incorporated herein, is the entire agreement between the parties and supersedes all prior or contemporaneous agreements and negotiations, either oral or in writing, with respect to the subject matter hereof.

- Part 1 - Cover and Signature
- Part 2 - Definitions
- Part 3 - Terms and Provisions
- Part 4 - Federal and State Regulatory Provisions, with Exhibits
- Part 5 - Programs, Rates, and Services
- Part 6 - Participation Schedule

9.14 Survival. The provisions of sections noted herein including but not limited to 2.9, 5.1, 5.2, 5.3, 6.2, 7.4, 8.2, 9.7 and 9.14 shall survive the expiration of termination of this Agreement regardless of cause.

9.15 Approval. This Agreement is subject to State approval as to form. The parties agree to incorporate into this Agreement any and all modifications required by the State, or alternatively, to terminate this Agreement if so directed by the State.

9.16 Force Majeure. If either Party shall be delayed or interrupted in the performance or completion of its obligations hereunder by any act, neglect or default of the other Party, or by an embargo, war, act of terror, riot, incendiary, fire, flood, earthquake, hurricane epidemic or other calamity, act of God or of the public enemy, governmental act (including, but not restricted to, any government priority, preference, requisition, allocation, interference, restraint or seizure, or the necessity of complying with any governmental order, directive, ruling or request) then the time of completion specified herein shall be extended for a period equivalent to the time lost as a result thereof, provided however, if Provider's inability to provide the services extends for sixty (60) days or more ILS Community Network may, at its sole discretion immediately terminate this Agreement. This Section 9.16 shall not apply to either Party's obligations to pay any amounts owing to the other Party, nor to any strike or labor dispute involving such Party or the other Party.

9.17 Provider insolvency or filing of petition in bankruptcy. The Provider must give ILS Community Network written notification promptly of the insolvency of the Provider or any subcontractor, or of the filing of a petition in bankruptcy by the Provider or any subcontractor. The Provider report to ILS Community Network shall include (1) the date of filing of the bankruptcy petition; (2) the case number; (3) the court name and division in which the petition was filed; and (4) the name, address, and telephone number of the bankruptcy attorney.

9.18 Discrimination Prohibited. Discrimination of any kind is prohibited with respect to participation, reimbursement, or indemnification of any Provider who is acting within the scope of his/her/its license or certification under applicable state law, solely on the basis of such license or certification. This provision should not be construed as a willing provider law, as it does not prohibit the Managed Care Plan from limiting provider participation to the extent necessary to meet the needs of the enrollees. This provision does not interfere with measures established by the Managed Care Plan that are designed to maintain quality and control costs. The Managed Care Plan will not discriminate against Providers serving high-risk populations or those that specialize in conditions requiring costly treatments. The Provider will not discriminate against any enrollee on the basis of any factor related to health status, including without limitation medical condition, including mental and physical illness, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, including conditions arising out of acts of domestic violence, or disability. Provider agrees to observe the provisions of Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975 and the Americans with Disabilities Act.

Part 4 - Federal and State Regulatory Provisions

State Regulatory Provisions and Standard Clauses

Standard Clauses. The State Standard Clauses for Managed Care Provider and/or Programs below are expressly incorporated into this Agreement and are binding upon the parties to this Agreement. In the event of any inconsistent or contrary language between the State Standard Clauses and any other Part of this Agreement, including but not limited to appendices, amendments and exhibits, the parties agree that the provisions of the State Standard Clauses shall prevail.

The Provider warrants and attests that the Provider is eligible to participate in the State Medicaid program and will comply with the following terms and conditions:

(1) Provider Responsibilities. The Provider shall:

(a) Be liable for and indemnify, defend, and hold the State Medicaid Agency, Managed Care Plan, Enrollees and Government Sponsor harmless from all claims, suits, judgments, or damages, including court costs and attorney's fees, to the extent proximately caused by any negligent act or omission or other wrongful conduct relating to this Agreement. This clause must survive the termination of the Agreement, including breach due to insolvency. The State Medicaid Agency may waive this requirement for itself, but not Managed Care Plan Enrollees, for damages in excess of the statutory cap on damages for public entities, if the provider is a state agency or subdivision as defined by Mandates, or a public health entity with statutory immunity. All such waivers shall be approved in writing by the Agency.

(b) Comply with all of the requirements of Section 6032 (Employee Education About False Claims Recovery) of the Deficit Reduction Act of 2005, if the Provider receives or earns five million dollars or greater annually under a State Medicaid program. The Provider portal and/or Provider Manual will have online details or access to the following from Section 6032 of the federal Deficit Reduction Act of 2005:

- The False Claim Act;
- The penalties for submitted false claims and statements;
- Whistleblower protections;
- The law's role in preventing and detecting fraud, waste and abuse, and each person's responsibility relating to detection and prevention.

(c) By signature to this Agreement, the Provider does attest that all statements and information furnished by the prospective provider before signing the Agreement shall be true and complete. The filing of a materially incomplete, misleading or false application will make the application and agreement voidable at the option of the State or ILS Community Network and is sufficient cause for immediate termination of the provider from the State and Managed Care Plan Medicaid program and/or revocation of the provider number.

(d) Agree to notify ILS Community Network of any changes to the information furnished on the Provider Enrollment Application including changes of address, tax identification number, group affiliation, depository bank account if Electronic Fund Transfers, and principals. For this purpose, principals includes partners or shareholders of five (5) percent or more, officers, directors, managers, financial records custodian, medical records custodian, subcontractors, and individuals holding signing privileges on the depository account, and other affiliated person.

CMS Regulatory Provisions

This Agreement will comply with all applicable Federal and State laws and regulations including title VI of the Civil Rights Act of 1964; title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; and the Americans with Disabilities Act of 1990 as amended. Each party agrees to carry out all activities undertaken by it pursuant to this Agreement in conformance with the Mandates, the State, and the Centers for Medicare and Medicaid Services ("CMS").

This Agreement section shall apply to the services provided by Provider as such services relate to participating Managed Care Plan's contract with the Government Sponsors such as Centers for Medicare and Medicaid Services ("CMS") and/or Agency. With respect to the rendering of such services, the provisions of the Managed Care Plan's contract with the Government Sponsor Payor shall supersede any provision in this Agreement that may conflict or appear inconsistent with any provision in the contract between Managed Care Plan or Government Sponsor.

1. Provider Services and Activities. The following shall apply with respect to any services and activities for which Managed Care Plan is responsible under its contract with CMS and that have been "delegated" to Provider under the Agreement:

(a) Provider shall provide or arrange for the provision of the services set forth in the Agreement.

(b) Provider shall comply with any reporting responsibilities as are set forth in the Agreement, the Provider Handbook, or Managed Care Plan bulletins about the submission of reports and clinical information required by the Managed Care Plan, including CHCUP reporting (if applicable).

(c) Provider shall comply with Mandates and all applicable Medicare laws, regulations and CMS instructions and cooperate with Managed Care Plan in its efforts to comply with the laws, regulations and other requirements of applicable regulatory authorities. Provider shall perform the services set forth in the Agreement in a manner consistent with and in compliance with Managed Care Plan's contractual obligations under Managed Care Plan's contract with CMS.

(d) If the Agreement provides for the performance by Provider of any activities related to the credentialing of health care providers, Provider must meet all applicable CMS requirements for credentialing, including that the credentials of medical professionals are either reviewed by Managed Care Plan or that the credentialing process must be reviewed, pre-approved and is periodically subject to audit by Managed Care Plan.

(e) If the Agreement provides for the selection by Provider of health care providers to be participating providers in Managed Care Plan's Medicare Advantage network, Managed Care Plan retains the right to approve, suspend or terminate the participation status of such health care providers.

(f) Provider acknowledges that Managed Care Plan oversees on an on-going basis, and is ultimately accountable to CMS for all functions, duties or responsibilities that are contained in Managed Care Plan's contract with CMS, including those that Provider has agreed to perform in accordance with the Agreement. In instances where CMS or Managed Care Plan determines that Provider has not performed satisfactorily or has failed to meet all reporting and disclosure requirements in a timely manner, Managed Care Plan has the right to revoke and assume the delegated activities or reporting and disclosure requirements upon written notice to Provider, or Managed Care Plan may terminate the Agreement upon 45 days advance written notice to Provider. Provider shall cooperate with Managed Care Plan regarding any delegated activities or reporting and disclosure requirements that have been revoked and assumed by Managed Care Plan.

(g) If Provider has any arrangements with subcontractors, directly or through another person or entity, to perform any of the services Provider is obligated to perform under the Agreement, Provider shall ensure that all such arrangements are in writing and duly executed by an authorized individual. Provider shall also ensure that all such agreements incorporate the terms contained in this Agreement and shall provide notice to Managed Care Plan of such agreement or amendment of such agreement. Provider shall ensure that the terms of this Agreement are included in all future and pending agreements with subcontractors that relate to the same subject matter. Provider further agrees to promptly amend the agreements with subcontractors, in the manner requested by Managed Care Plan, to meet any additional CMS or other Mandate requirements.

2. Accountability provisions:

   (a) First tier and downstream entities must comply with Medicare laws, regulations, and CMS instructions (422.504(i)(4)(v)), and agree to audits and inspection by CMS and/or its designees and to cooperate, assist, and provide information as requested, and maintain records a minimum of 10 years, or time period required by regulations if different.

   (b) The Managed Care Plan oversees and is accountable to CMS for any functions and responsibilities described in the Medicare Advantage (MA) regulations (422.504(i)(4)(iii)).

   (c) If the Managed Care Plan chooses to delegate functions they must adhere to the delegation requirements - including all provider contract requirements in these delegation requirements - described in the MA regulations (422.504(i)(3)(iii); 422.504(i)(4)(i)-(v)).

   (d) If there is a Managed Care Plan Provider incentive plan, the Managed Care Plan shall make no specific payment directly or indirectly under a Provider incentive plan to a provider as an inducement to deny, reduce limit, or discontinue medically necessary services to an enrollee, and that incentive plans shall not contain provisions that provide incentives, monetary or otherwise, for withholding medically necessary care.

3. The Agreement will comply with:

   (a) The requirements mandating provider identification of provider-preventable conditions as a condition of payment, as well as the prohibition against payment for provider-preventable conditions as set forth in §434.6(a)(12) and §447.26 including the reporting of all identified provider-preventable conditions in a form or frequency as may be specified by the State.

   (b) The requirements set forth in §§422.208 and 422.210 related to Physician incentive plans.

   (c) The requirements of §422.28 for maintaining written policies and procedures for advance directives. Including compliance with the requirements of §422.128 for maintaining written policies and procedures for advance directives when the Managed Care Plan includes, in its network, any of those providers listed in §489.102(a).

4. Provider agrees to comply with all applicable Medicare laws, regulations, and CMS instructions. 422.504(i)(4)(v)

5. Provider agrees to comply with all State & Federal requirements for accuracy & confidentiality of enrollee records, including the requirements established by Managed Care Plan and the Medicare Advantage (MA) program. 422.118; 422.504(a)(13)

6. The responsibilities of the administrative services provider are network development and there will be a monthly report showing current, potential and recently added and or terminated providers to the network. 422.504(a)(8)

7. Managed Care Plan has the right to revoke the contract if any first tier and/or downstream entity does not perform the services satisfactorily and if reporting and disclosure requirements are not timely. 422.504(i)(4)(ii)

8. Any services performed will be consistent with and comply with Managed Care Plan's contractual obligations with CMS.422.504(i)(1); 422.504(i)(3)(iii)

9. If credentialing is delegated, the Provider must meet all Managed Care Plan and ILS Community Network credentialing requirements, and the credentials of medical professionals will be either reviewed by the Managed Care Plan or ILS Community Network; or the credentialing process will be reviewed, approved, & audited by the Managed Care Plan or ILS Community Network on an ongoing basis. 422.504(i)(4)(iv)(A)/(B)

10. When Managed Care Plan delegates the selection of providers, written arrangements will state that Managed Care Plan retains the right to approve, suspend, or terminate any such arrangement. 422.504(i)(5)

11. The contract acknowledges that the responsibilities performed by the Provider and/or any delegated administrative service entities are monitored by the Managed Care Plan or ILS Community Network on an ongoing basis and that the Managed Care Plan is ultimately responsible to CMS for the performance of all services. 422.504(i)(1) & (4)

12. The contract between Managed Care Plan or ILS Community Network and the Provider and between the Provider and downstream entities incorporate provisions specifying Medicare Advantage Organization delegation requirements specified at section 422.504(i)(3)(iii); 422.504(i)(4) and 422.504(i)(5)

13. This Agreement does not contain any provision restricting the Provider's ability to communicate to the Provider's patient regarding medical care or treatment options for the patient when the Provider deems knowledge of such information by the patient to be in the best interest of the health of the patient.

14. This agreement gives the U.S. Department of Health and Human Services (HHS), the General Accounting Office (GAO) and designees right to audit etc. for 10 years or periods exceeding 10 years or completion of an audit, whichever is later.

15. The Provider must provide for continuation of enrollee health care benefits (i) For all enrollees, for the duration of the contract period for which CMS payments have been made; and (ii) For enrollees who are hospitalized on the date its contract with CMS terminates, or, in the event of insolvency, through discharge.

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EXHIBIT E Medicare Advantage, Medicaid and Reform Medicaid

(Provisions of Exhibit E Apply to services rendered to Medicare Advantage Enrollees, Medicaid Managed Care Plan Enrollees, and Enrollees enrolled in both Medicare Advantage and a Medicaid Managed Care Plan)

1. **Additional Provisions** The provisions set forth in this Exhibit E are hereby incorporated into the Agreement and ILS Community Network and Provider agree to the following provisions

   1) **Enrollee Privacy and Confidentiality.** Provider agrees to comply with all state and federal laws, rules and regulations, Medicare program requirements, applicable Medicaid requirements and/or requirements in the Medicare Contract and applicable Medicaid requirements regarding privacy, security, confidentiality, accuracy and/or disclosure of records (including, but not limited to, medical records), personally identifiable information and/or protected health information and enrollment information including, without limitation: (1) HIPAA and the rules and regulations promulgated there under, (2) 42 CFR 420.205, and 42 C.F.R. § 422.504(a)(13), and (3) 42 C.F.R. § 422.118; (iv) 42 C.F.R. § 422.516, and 42 C.F.R. § 422.310 regarding certain reporting obligations to CMS. Provider also agrees to release such information only in accordance with applicable State and/or Federal law or pursuant to court orders or subpoenas.

   2) **Compliance with Law.** Provider agrees to comply with all applicable Medicare and Medicaid laws, rules and regulations, reporting requirements, CMS instructions, and applicable requirements of the contract between Managed Care Plans and CMS (the "Medicare Contract") and with all other applicable state and federal laws and regulations, as may be amended from time to time, including, without limitation: (1) Federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including, but not limited to, applicable provisions of Federal criminal law, the False Claims Act (31 U.S.C. 3729 et. seq.), and the anti-kickback statute (section 1128B(b)) of the Act); and (2) applicable state laws regarding patients' advance directives as defined in the Patient Self Determination Act (P.L. 101-58) ; (3) Federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA") administrative simplification rules at 45 C.F.R. parts 160, 162, and 164. [42 C.F.R. § 422.504(h)]; (4) business related disclosure requirements under 42 CFR 438.230, 42 CFR 455.104, 42 CFR 455.105, and 42 CFR 455.106.

   3) **Prompt Payment of Claims.** ILS Community Network agrees to process and pay or deny claims for Covered Services within sixty (60) calendar days of receipt of such claims in accordance with the Agreement, except as such time frame may be modified by Mandates or reflected in the State Exhibit/Addenda hereto. [42 C.F.R. § 422.520(b).]

   4) **Accountability**. ILS Community Network hereby acknowledges and agrees that Managed Care Plans shall oversee the provision of services by Provider and ILS Community Network and shall be accountable as applicable under the Medicare Contract, Medicaid or Reform Medicaid for services provided to its Enrollees (each a "Enrollee") under the Agreement regardless of the provisions of the Agreement or any delegation of administrative activities or functions to Provider under the Agreement. [42 C.F.R. § 422.504(i)(1); (i)(4)(iii); and (i)(3)(ii).]

5) **Compliance with ILS Community Network and Managed Care Plan Policies and Procedures.** Provider shall comply with all policies and procedures of ILS Community Network and Managed Care Plans including, without limitation, written standards for the following: (a) timeliness of access to care and Enrollee services; (b) policies and procedures that allow for individual medical necessity determinations (e.g., coverage rules, practice guidelines, payment policies); (c) Provider consideration of Enrollee input into Provider's proposed treatment plan; and (d) Managed Care Plan's accreditation standards; and (e) Managed Care Plan's compliance program which encourages effective communication between Provider and Managed Care Plan's Compliance Officer and participation by Provider in education and training programs regarding the prevention, correction and detection of fraud, waste and abuse and other initiatives identified by CMS. The aforementioned policies and procedures are identified in ILS Community Network and Managed Care Plan Provider Handbook and related Bulletins which are incorporated herein by reference and may be amended from time to time by ILS Community Network or Managed Care Plan. [42 C.F.R. § 422.112; 422.504(i)(4)(v); 42 C.F.R. § 422.202(b); 42 C.F.R. § 422.504(a)(5); 42 C.F.R. § 422.503(b)(4)(vi)(C) & (D) & (G)(3).]

6) **Continuation of Benefits.** Provider agrees that except in instances of immediate termination by ILS Community Network or Managed Care Plan for reasons related to professional competency or conduct and upon expiration or termination of the Agreement, Provider will continue to provide Covered Services to Enrollees as indicated below and to cooperate with ILS Community Network or Managed Care Plan to transition Enrollees to other Participating Providers in a manner that ensures medically appropriate continuity of care. In accordance with the requirements of the Medicare Contract, ILS Community Network 's or Managed Care Plan's accrediting bodies and applicable law and regulation, Provider will continue to provide Covered Services to Enrollees after the expiration or termination of the Agreement, whether by virtue of insolvency or cessation of operations of ILS Community Network or Managed Care Plan, or otherwise: (i) for those Enrollees who are confined in an inpatient facility on the date of termination until discharge; (ii) for all Enrollees through the date of the applicable Medicare Contract for which payments have been made by CMS to ILS Community Network or Managed Care Plan; and (iii) for those Enrollees undergoing active treatment of chronic or acute medical conditions as of the date of expiration or termination through their current course of active treatment not to exceed ninety (90) days unless otherwise required by item (ii) above. [42 C.F.R. 422.504(g) (2) & (3).]

7) **Hold Harmless of Dual Eligible Enrollees.** With respect to those Managed Care Plan Enrollees who are designated as Dual Eligible Enrollees for whom the State Medicaid agency is otherwise required by law, and/or voluntarily has assumed responsibility in the State Medicaid Managed Care Plan to cover those Medicare Part A and B Enrollee Expenses identified and at the amounts provided for in the State Medicaid Managed Care Plan, Provider acknowledges and agrees that it shall not bill Managed Care Plan Enrollees the balance of ("balance-bill"), and that such Managed Care Plan Enrollees are not liable for, such Medicare Part A and B Enrollee Expenses, regardless of whether the amount Provider receives is less than the allowed Medicare amount or Provider charges due to limitations on additional reimbursement provided in the State Medicaid Managed Care Plan. Provider agrees that it will accept Managed Care Plan's payment as payment in full or will bill the appropriate State source if Managed Care Plan has not assumed the State's financial responsibility under an agreement between Managed Care Plan and the State. Provider shall not collect any cost share amounts from a

Medicare Advantage Enrollee who has been designated as a Qualified Medicare Beneficiary ("QMB") by CMS.

8) **Federal Funds.** Provider acknowledges that payment from applicable Managed Care Plan (hereinafter "Payor Plan") to ILS Community Network for services to Medicare Advantage, Medicaid and Reform Medicaid enrollees is derived in whole or in part from federal funds received by Payor Plan from CMS, and that Provider shall be subject to those laws, rules and regulations applicable to individuals and entities receiving federal funds.

9) **Audits: Access and Record Retention**. Provider shall permit and cooperate fully in any investigation, audit, evaluation and inspection and in any subsequent legal action that may result from such an investigation involving this Agreement by Managed Care Plan, the Department of Health and Human Services (HHS), the Comptroller General, the Office of the Inspector General, the General Accounting Office, CMS, State Medicaid Agency, MPI, MFCU, Government Sponsor or other state or federal entity and/or their designees, and as the Secretary of the HHS may deem necessary to enforce the Medicare Contract or Medicaid Contract, physical facilities and equipment and any pertinent information including books, contracts (including any agreements between Provider and its employees, contractors and/or subcontractors providing services related to the Agreement), documents, papers, medical records, patient care documentation and other records and information involving or relating to the provision of services under the Agreement, and any additional relevant information that CMS may require (collectively, "Books and Records"). All Books and Records shall be maintained in an accurate and timely manner and shall be made available for such inspection, evaluation or audit for a time period of not less than ten (10) years, or such other period of time as may be required by law, from the end of the calendar year in which expiration or termination of this Agreement occurs or from completion of any audit or investigation, whichever is greater, unless CMS, an authorized federal agency, or such agency's designee, determines there is a special need to retain records for a longer period of time, which may include but not be limited to: (i) up to an additional six (6) years from the date of final resolution of a dispute, allegation of fraud or similar fault; (ii) completion of any audit should that date be later than the time frame(s) indicated above; (iii) if CMS determines that there is a reasonable possibility of fraud or similar fault, in which case CMS may inspect, evaluate, and audit Books and Records at any time; or (iv) such greater period of time as provided for by law. Provider shall cooperate and assist with and provide such Books and Records to Managed Care Plan and/or CMS or its designee for purposes of the above inspections, evaluations, and/or audits, as requested by CMS or its designee and shall also ensure accuracy and timely access for Enrollees to their medical, health and enrollment information and records. Provider agrees and shall require its employees, contractors and/or subcontractors and those individuals or entities performing administrative services for or on behalf of Provider and/or any of the above referenced individuals or entities: (i) to provide Managed Care Plan and/or CMS with timely access to records, information and data necessary for: (1) Managed Care Plan to meet its obligations under its Medicare Contract(s); and/or (2) CMS to administer and evaluate the MA program; and (ii) to submit all reports and clinical information required by Managed Care Plan under the Medicare Contract. [42 C.F.R. §§ 422.504(e)(4), 422.504 (h), 422.504(i)(2)(i), 422.504(i)(2)(ii) and 422.504(i)(4)(v).]

10) **Data Collection/ Accurate Information.** With respect to Medicare Advantage, Medicaid and Reform Medicaid patients, Provider acknowledges that Payor Plan is required by CMS to maintain a health information system that collects, analyzes and integrates all data necessary to compile, evaluate and report certain statistical data related to costs, utilization and quality, and such other matters as CMS may require from time to time. Provider hereby agrees to submit to ILS Community Network or Payor Plan, upon request, and in a timely manner, all information and/or data necessary for Payor Plan to fulfill these obligations, and within the timeframes specified by ILS Community Network or Payor Plan to meet CMS requirements. Provider hereby represents and warrants that all data including, but not limited to, encounter data and other information submitted to ILS Community Network by Provider shall be truthful, reliable, accurate and complete, and upon request by ILS Community Network Provider agrees to certify that such information is truthful, reliable, accurate and complete. Provider further agrees to hold harmless and indemnify ILS Community Network and Payor Plan for any fines or penalties they may incur due to Provider's submission of inaccurate or incomplete data.

11) **Cooperation.** Provider agrees to cooperate with any independent quality review and improvement organization utilized by or under contract with Payor Plan pertaining to the provision of services for Medicare Advantage, Medicaid and/or Reform Medicaid enrollees. Provider shall comply with applicable ILS Community Network and Payor Plan policies and, if requested by ILS Community Network, shall cooperate in developing and implementing medical policy, quality assurance programs, and medical management programs applied to Medicare Advantage Medicaid and/or Reform Medicaid enrollees.

12) **Participation in Medicare and/or Medicaid.** Provider hereby represents that Provider and all employees, subcontractors and/or independent contractors of Provider providing or who will provide services under the Agreement, including without limitation health care, utilization review, medical social work and/or administrative services, each maintains full participation status in the Medicare program and/or the applicable state Medicaid program and/or is not excluded from participation in the Medicare program or applicable state Medicaid program. ILS Community Network may terminate the Agreement immediately upon Provider's failure to adhere to the terms of this provision.

13) **Standards of Care.** Payor Plan and ILS Community Network agree to provide all covered benefits to Medicare Advantage and, as applicable, Medicaid and Reform Medicaid enrollees in a manner consistent with professionally recognized standards of care. Provider shall offer hours of operation that are no less than the hours of operation offered to commercial Managed Care Plan Enrollees or comparable Medicaid fee-for service recipients if the Provider serves only Medicaid recipients.

14) **Additional Termination Provisions.** Notwithstanding any provision in the Agreement, the following termination provisions shall apply to Provider if rendering services to Medicare Advantage, Medicaid or Reform Medicaid enrollees:

    a. ILS Community Network may terminate the Agreement immediately upon request of Payor Plan due to Provider's loss or suspension of licensure or certification, or sanction by Medicare or applicable Medicaid program.

b. ILS Community Network may terminate the Agreement upon thirty (30) days prior written notice to Provider for Provider's failure to cooperate and/or comply with any of the provisions of the Agreement.

c. If Provider wishes to terminate the Agreement without cause, it must provide the other party with no less than sixty (60) days prior written notice.

15) **Delegation of Provider Selection.** As applicable, Provider understands that if selection of providers who render services to Managed Care Plan Enrollees has been delegated to ILS Community Network and/or Provider by Managed Care Plan, either expressly or impliedly, then Managed Care Plan retains the right to approve, suspend or terminate such downstream or subcontracted arrangements. [42 C.F.R. § 422.504 (i) (5).]

16) **Delegation Requirements.** Provider understands and acknowledges that if any of the Payor Plan's activities or responsibilities under its contract with CMS, related to the provision of services to Medicare Advantage, Medicaid or Reform Medicaid enrollees, are delegated to other parties, the following requirements apply to any such Affiliate:

a. Written arrangements must specify delegated activities, reporting and monitoring responsibilities. Including monitoring and oversight by the Managed Care Plan and the Provider to assure that all licensed medical professionals are credentialed in accordance with the Managed Care Plan's and the State Agency's credentialing requirements as found in the applicable Government Sponsored program contract.

b. In the event that CMS or Managed Care Plan determines that the provider or ILS Community Network does not satisfactorily perform the delegated activities or satisfy any plan of correction, any and all of the delegated activities may be revoked upon notice by Managed Care Plan to ILS Community Network or Provider.

c. Written arrangements must specify that the performance of the parties is monitored by the Payor Plan on an ongoing basis and formally reviewed at least annually.

d. The credentials for Providers contracted with ILS Community Network will either be reviewed by Managed Care Plan or in the event Managed Care Plan has delegated credentialing to ILS Community Network, the process will be reviewed and approved by Managed Care Plan, monitored on an ongoing basis and audited at least annually.

e. Provider understands that ILS Community Network or Provider may not delegate, transfer or assign any obligations with Enrollees or any delegation agreement without Managed Care Plan's prior written consent.

17) **Appeals.** Provider will adhere to Medicaid and Medicare appeals procedures for enrollees, as applicable, including the procedures for expedited appeals. Provider shall gather and forward information on enrollee appeals to ILS Community Network or Payor Plan to the extent required by law or regulation so as to enable Payor Plan to meet the CMS required time frames for grievances and appeals.

18) **Compliance with Policies.** To the extent that a Medicare Advantage, Medicaid or Reform Medicaid requirement is found in a policy, the Provider Handbook or other

procedural guide of ILS Community Network and/or Payor Plan and is not otherwise specified in the Agreement, Provider will comply with those policies, manuals and procedures with regard to the provision of care to Medicare Advantage, Medicaid and/or Reform Medicaid enrollees. Written notice of changes to applicable policies, including the Provider Handbook, shall be provided to Provider prior to the effective date of such changes by email notification, posting to ILS Community Network's website or other means.

19) **Failure to Comply.** If ILS Community Network denies payment to Provider due to Provider's failure to comply with any of the provisions of the Agreement, Provider shall not bill the enrollee for the denied amounts.

20) **Amendment.** ILS Community Network may amend this Attachment as needed to comply with applicable state and federal laws, rules and regulations, and shall provide Provider with written notice of such amendment and its effective date. Unless required by such law, rule or regulation, Provider's signature will not be required to implement such amendment.

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EXHIBIT I - FLORIDA MEDICAID ADDENDUM (Updated 2017)

THIS MEDICAID ADDENDUM (the "Addendum") supplements the terms and conditions of that certain Provider Services Agreement (the "Agreement") by and between Independent Living Systems, L.L.C. (herein as "ILS" or "ILS Community Network") and the Managed Care Plan identified in Part 6-Program Participation Schedule (the "Managed Care Plan") and

____("Provider") identified in Part 1-Cover and Signature Page. The provisions of this Addendum shall apply to all services provided by Provider to ILS Community Network or Managed Care Plan Enrollees eligible for Medicaid services in the State of Florida. "Agency", "State Medicaid Agency" or "AHCA" refers to the Florida Agency for Health Care Administration. "SMMC" refers to the Florida Statewide Medicaid Managed Care for both components (LTC and MMA). When the Managed Care Plan has entered into an agreement with AHCA (the "Medicaid Contract") to arrange for the provision of health care services to Members eligible for the Medicaid Program and enrolled in a Medicaid Benefit Plan offered by the Managed Care Plan (the "Medicaid Benefit Plan").

This Addendum is entered into for the purpose of ensuring compliance with Florida and Federal Medicaid laws, rules and regulations with respect to the Medicaid Benefit Plan, which includes SMMC, and applies to Provider in its provision of services to Managed Care Plan. This Addendum and the Agreement shall comply with 42 C.F.R. 438.230, 42 C.F.R 455.104, 42 C.F.R. 455.105 and 42 C.F.R. 455.106. All capitalized terms not set forth herein shall have the meanings set forth in the Agreement.

The provisions of this Addendum supplement the terms of the Agreement and are to be interpreted in a manner consistent with the terms of the Agreement, provided that to the extent the terms and conditions set forth in this Addendum conflict and cannot be reconciled with similar provisions elsewhere in the Agreement with respect to the provision of health care services to Medicaid Enrollees, the terms and conditions in this Addendum shall prevail. In addition, to the extent that the terms or conditions of this Addendum conflict with a Medicaid Contract, the Medicaid Contract shall control as to Medicaid Enrollees who are enrolled in a Medicaid Benefit Plan. Since the provisions of this Addendum apply to Provider, its professional staff, employees, contractors, subcontractors and individuals or entities performing services for or on behalf of Provider or any of the above-named individuals or entities performing services related to the Agreement, all references to Provider herein shall also be references to professional staff, employees, contractors, subcontractors and individuals or entities performing services for or on behalf of Provider.

ILS Community Network, Managed Care Plan, and Provider acknowledge and agree that:

1. Provider shall and shall cause each member of its professional staff to comply with and abide by all applicable terms and conditions of the Medicaid Contract as well as all related state and federal laws, rules, regulations and guidelines related to the Medicaid lines of business. Including covered services promptly per 42 U.S.C. §1396a(a)(8)).

2. Enrollee may choose among participating providers in accordance with 42 CFR 431.51

3. Home and Community Based “HCB” Settings Requirement Language provided by the Agency for Assisted Living Facility “ALF”, Adult Family Care Home “AFCH”, and Adult Day Health Center “ADHC” providers is incorporated herein and as may be amended by the Agency.

4. ALFs shall be in compliance with the Assisted Care Communities Resident Bill of Rights per s. 429.28, F.S.

5. Provider shall develop and maintain policies and procedures for back-up plans in the event of absent employees, and each provider shall maintain sufficient staffing levels to ensure that service delivery is not interrupted due to absent employees;

6. If Provider is a residential facility, Provider shall collect patient responsibility in accordance with the terms and conditions of this Agreement, Managed Care Plan identified in Part 6-Program Participation Schedule Provider Handbook and the Medicaid Contract. Provider shall not assess late fees.

7. If the Provider identified in Part 1-Cover and Signature Page (and as may be additionally identified on the first page of this Medicaid Addendum) is an ALF or AFCH Provider, said Provider will support the enrollee’s community inclusion and integration by working with the case manager and enrollee to facilitate the enrollee’s personal goals and community activities. Enrollees residing in ALF/AFCH Provider facility shall be offered services with the following options unless medical, physical, or cognitive impairments restrict or limit exercise of these options.

   Choice of:
   - Private or semi-private rooms, as available;
   - Roommate for semi-private rooms;
   - Locking door to living unit;
   - Access to telephone and unlimited length of use;
   - Eating schedule;
   - Activities schedule; and
   - Participation in facility and community activities.

   Ability to have:
   - Unrestricted visitation; and
   - Snacks as desired.

   Ability to:
   - Prepare snacks as desired; and
   - Maintain personal sleeping schedule.

8. If the Provider identified in Part 1-Cover and Signature Page (and as may be additionally identified on the first page of this Medicaid Addendum) is an ALF Provider, said ALF Provider hereby agrees to accept monthly payments from Managed Care Plan identified in Part 6-Program Participation Schedule for enrollee services as full and final payment for all Long-term Care services detailed in the enrollee’s plan of care which are to be provided by ALF Provider. Enrollees remain responsible for the separate ALF room and

board costs as detailed in their resident contract. As enrollees age in place and require more intense or additional Long-term Care covered services, ALF Provider may not request payment for new or additional services from an enrollee, their family members or personal representative. ALF Provider may only negotiate payment terms for covered services pursuant to this provider contract with Managed Care Plan identified in Part 6-Program Participation Schedule.

9. If the Provider identified in Part 1-Cover and Signature Page (and as may be additionally identified on the first page of this Medicaid Addendum) is an ADHC Provider, said ADHC Provider will support the enrollee's community inclusion and integration by working with the case manager and enrollee to facilitate the enrollee's personal goals and community activities.

   Enrollees accessing adult day health services in Managed Care Plan identified in Part 6-Program Participation Schedule shall be offered services with the following options unless medical, physical, or cognitive impairments restrict or limit exercise of these options.

   Choice of:
   - Daily activities;
   - Physical environment
   - With whom to interact
   - Access to telephone and unlimited length of use;
   - Eating schedule;
   - Activities schedule; and
   - Participation in facility and community activities.

   Ability to have:
   - Right to privacy;
   - Right to dignity and respect;
   - Freedom from coercion and restraint; and
   - Opportunities to express self through individual initiative, autonomy, and independence

10. If the Provider identified in Part 1-Cover and Signature Page (and as may be additionally identified on the first page of this Medicaid Addendum) is a nursing facility or hospice, Provider shall maintain active Medicaid enrollment and submit required cost reports to AHCA for the duration of the Medicaid Contract.

11. Managed Care Plan shall not discriminate with respect to participation, reimbursement, or indemnification of Provider or its professional staff who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of such license or certification. This provision should not be construed as an "any willing" provider law, and it does not prohibit Managed Care Plan from limiting professional staff participation to the extent necessary to meet the needs of Medicaid Enrollees. Furthermore, this provision does not interfere with measures established by Managed Care Plan that are designed to maintain quality and control costs.

12. Managed Care Plan shall not discriminate against Provider or any member of its professional staff serving high-risk populations or those that specialize in conditions requiring costly treatments.

13. Nothing in this Addendum is intended to or shall (i) interfere with or hinder communications between Provider or its professional staff and Medicaid Enrollees regarding patient treatment; (ii) prohibit Provider or its professional staff from discussing treatment options or non-treatment options with Medicaid Enrollees that may not reflect Managed Care Plan's position or that may not be covered by the Medicaid Benefit Plan; (iii) prohibit Provider or its professional staff from acting within the lawful scope of practice, from advising or advocating on behalf of Medicaid Enrollee for the Medicaid Enrollee's health status, medical care, or treatment or non-treatment options, including any alternative treatments that might be self-administered; (iv) prohibit Provider or its professional staff from advocating on behalf of a Medicaid Enrollee in any grievance process, UM process, or individual authorization process to obtain necessary health care services; (v) require Provider to contract for more than one Managed Care Plan product or otherwise be excluded; (vi) prohibit or restrict Provider or its professional staff from entering into a commercial contract with any other Managed Care Plan; or (vii) prohibit Provider or its professional staff from providing inpatient services in a contracted hospital to Medicaid Enrollee if such services are determined to be Medically Necessary and are Covered Medical Services.
14. Provider shall offer hours of operation that are no less than the hours of operation offered to Members under different Benefit Plans offered by Managed Care Plan or comparable to non-reform Medicaid plans if only Medicaid recipients are served.
15. Provider shall immediately notify Managed Care Plan in writing of a Medicaid Enrollee's pregnancy, whether identified through medical history examination, testing, claims or otherwise.
16. If the Provider identified in Part 1-Cover and Signature Page (and as may be additionally identified on the first page of this Medicaid Addendum) is a nursing facility or hospice, said Provider shall establish and follow a bed hold days policy that comports with Medicaid FFS bed hold days policies and procedures.
17. Provider shall cause all direct service providers to complete abuse, neglect and exploitation training.
18. Provider agrees and shall cause each member of its professional staff to agree that a Medicaid Enrollee may be transferred immediately to another Provider if the Medicaid Enrollee's health or safety is in jeopardy.
19. Provider shall and shall cause each member of its professional staff to fully cooperate in all respects with other providers and health plans of transitioning Medicaid Enrollees to assure maximum health outcomes for Medicaid Enrollees.
20. Upon termination of this Agreement, the rights of each party hereunder shall terminate, provided however, that such action shall not release Provider or member of its professional staff of their obligations with respect to: (i) the continuation of Provider's obligations, and (ii) Provider's continuity of treatment and care for, Enrollees as provided in this Agreement. Managed Care Plan shall compensate Provider for such care pursuant to the terms of this Agreement. Provider further agrees that: (i) this provision shall survive the termination of this Agreement regardless of the cause giving rise to termination and (ii) shall be construed to be for the benefit of Enrollee and Managed Care Plan, as applicable. Upon notice of termination, Provider shall cooperate in all respects with Managed Care Plan, applicable Policies and Managed Care Plan protocols, if any, in the transitioning of Enrollees, and the continuity of treatment, to other

Providers or providers of another Managed Care Plan, to assure maximum health outcomes for Enrollees. A terminated provider may refuse to continue to provide care to an enrollee who is abusive or noncompliant.

21. Provider shall look solely to Managed Care Plan for compensation for services rendered hereunder, with the exception of nominal copayments or deductibles, pursuant to the Medicaid Contract. Neither Provider nor any member of its professional staff shall seek reimbursement or payment from Medicaid Enrollees for Covered Medical Services rendered to such Medicaid Enrollees pursuant to or in connection with this Agreement. Upon the termination or expiration of the Medicaid Contract, payment for all services performed for eligible Medicaid Enrollees prior to the effective date of termination will be the responsibility of Managed Care Plan. Provider shall not hold either Medicaid Enrollees or AHCA liable for the debts of Provider at any time, including termination of the Agreement or this Addendum for any reason, including the insolvency of Managed Care Plan.
22. Payment of any claims by Managed Care Plan shall be accompanied by an itemized accounting of the individual claims included in the payment, including but not limited to, the Medicaid Enrollee's name, date of service, the procedure code, the service units, the amount of reimbursement and the identification of the Medicaid Benefit Plan under which payment is being made.
23. Provider shall and shall cause each member of its professional staff to cooperate with and participate in Managed Care Plan's peer review, grievance, quality assurance and management program and utilization review and activities, and provide for monitoring and oversight, including monitoring of services rendered to Medicaid Enrollees, by the Managed Care Plan (or its subcontractor). Provider and each member of its professional staff rendering Covered Medical Services shall be licensed and credentialed in accordance with Managed Care Plan's, or its designee's, credentialing and re-credentialing policies and procedures, this Addendum and Managed Care Plan's Medicaid Contract. The Provider Handbook and/or an Exhibit to "Part 5-Programs, Rates, and Services" of the Agreement will identify the measures used by the Managed Care Plan to monitor the quality and performance of the provider.
24. Provider shall and shall cause each member of its professional staff to comply with Managed Care Plan's cultural competency plan, as described in Managed Care Plan's Provider Handbook.
25. Provider agrees and shall cause each member of its professional staff to agree that any community outreach and displayed marketing materials relating to Managed Care Plan's Medicaid Contract and Provider's participation in the Medicaid Benefit Plan, must be submitted by Managed Care Plan to AHCA for written approval before use. Provider shall and shall cause each member of its professional staff to comply with all community outreach and marketing requirements set forth in the Medicaid Contract.
26. Provider shall and shall cause each member of its professional staff to maintain adequate record systems for recording services, charges, dates and all other commonly accepted information elements for services rendered to Managed Care Plan and Medicaid Enrollees.
27. Provider agrees and shall cause each member of its professional staff to agree that all records pertaining to the provision of Covered Medical Services under this Addendum be maintained for a period not less than six (6) years from the close of the Medicaid

Contract, and retained further if the records are under review or audit until the review or audit is complete. Prior approval for the disposition of records must be requested and approved by Managed Care Plan if the Agreement is continuous.

28. Provider shall and shall cause each member of its professional staff to provide DHHS, the Florida Department of Elder Affairs, AHCA, including AHCA's Bureau of Medicaid Program Integrity (MPI) and the Medicaid Control Fraud Unit (MFCU), the right to inspect, evaluate, and audit all of the following related to Managed Care Plan's provision of services under its Medicaid Contract:
    - Pertinent books,
    - Financial records
    - Medical Records, and
    - Documents, papers, and records of Provider or its professional staff involving financial transactions related to this Addendum.
29. Provider agrees and shall cause each member of its professional staff to agree to submit information for reports and clinical information, including without limitation Child Health Check-up where applicable, to Managed Care Plan and/or AHCA, upon request.
30. Provider shall and shall cause each member of its professional staff to submit timely, accurate and complete encounter data to Managed Care Plan in accordance with the requirements of the Medicaid Contract.
31. Provider agrees and shall cause each member of its professional staff to agree that it is required to cooperate fully in any audit, investigation or review by Managed Care Plan, AHCA, MPI, MFCU, Florida Department of Elder Affairs or other state or federal entity and in any subsequent legal action that may result from such an audit, investigation or review involving the Agreement.
32. Provider agrees that it and its independent contractors and employees are subject to background checks conducted by Managed Care Plan. Managed Care Plan shall consider the nature of the work being performed in determining the level and scope of the background check. Provider agrees that it and its independent contractors and employees will cooperate with Managed Care Plan in connection with its performance of any and all background checks under and pursuant to this Agreement.
33. Provider agrees and shall cause each member of its professional staff to agree to safeguard information about Medicaid Enrollees according to 42 C.F.R. Part 438.224.
34. Provider shall and shall cause each member of its professional staff to comply with HIPAA privacy and security requirements.
35. In the event that Provider terminates the Agreement for any reason, it shall submit advance written submit notice of withdrawal from the network at least ninety (90) days before the effective date of such withdrawal.
36. Provider agrees that in addition to any other right to terminate, and notwithstanding any other provision of this Contract, the Agency or the Managed Care Plan may request immediate termination of the Agreement if, as determined by the Agency, Provider fails to abide by the terms and conditions of the Agreement, or in the sole discretion of the Agency, Provider fails to come into compliance with the Agreement within fifteen (15)

days after receipt of notice from Managed Care Plan specifying such failure and requesting Provider to abide by the terms and conditions thereof.

37. Provider agrees that in the event Provider is suspended or terminated for any reason, Provider may only utilize the applicable appeals procedures outlined in the Provider Handbook. No additional or separate right of appeal to AHCA or Managed Care Plan is created as a result of Managed Care Plan's act of suspending or terminating Provider. Notwithstanding the termination of the provider contract with respect to any particular provider, this Contract shall remain in full force and effect with respect to all other providers.

38. Provider shall look solely to Managed Care Plan for compensation for services rendered hereunder, with the exception of nominal copayments or deductibles, pursuant to the Medicaid Contract. Neither Provider nor any member of its professional staff shall seek reimbursement or payment from Medicaid Enrollees for Covered Medical Services rendered to such Medicaid Enrollees pursuant to or in connection with this Agreement. Upon the termination or expiration of the Medicaid Contract, payment for all services performed for eligible Medicaid Enrollees prior to the effective date of termination will be the responsibility of Managed Care Plan. Provider shall not hold either Medicaid Enrollees or AHCA liable for the debts of Provider at any time, including termination of the Agreement or this Addendum for any reason, including the insolvency of Managed Care Plan.

39. Provider shall secure and maintain workers' compensation insurance coverage for all of its employees connected with services provided to Medicaid Enrollees pursuant to the Medicaid Contract and in compliance with the Florida Workers' Compensation Laws.

40. Providers will notify the Managed Care Plan in the event of a lapse in general liability or medical malpractice insurance, or if assets fall below the amount necessary for licensure under Florida statutes.

41. Provider shall and shall cause each member of its professional staff to indemnify and hold AHCA and any Medicaid Enrollee harmless from and against any and all claims, damages, causes of action, costs or expense, including court costs and reasonable attorneys' fees, to the extent proximately caused by any negligent act or other wrongful conduct arising from the Agreement. This clause survives the termination of the Agreement, including breach due to insolvency. AHCA may waive may waive this requirement for itself, but not Medicaid Enrollees, for damages in excess of the statutory cap on damages for public entities, if the provider is a state agency or subdivision as defined by s. 768.28, F.S., or a public health entity with statutory immunity. All such waivers shall be approved in writing by the AHCA.

42. Any contracts, agreements, or subcontracts entered into by Provider for the purposes of carrying out any aspect of the Agreement or this Addendum must include assurances that the individuals who are signing the contract, agreement or subcontract are so authorized and that it includes all the requirements of the Agreement, this Addendum, and the Medicaid Contract as applicable. Provider acknowledges and agrees that if the performance of Provider or any professional staff member or the performance of their respective subcontractors, as it relates to the Agreement, this Addendum, or the

Medicaid Contract, is inadequate, Managed Care Plan shall have the right to revoke the delegation of duties and obligations under this Agreement and to, or impose other sanctions on, Provider and its professional staff. Furthermore, Provider will be obligated to revoke the delegation of duties and obligations to, or impose other sanctions on, its subcontractors at the request of Managed Care Plan.

43. If Managed Care Plan and Provider enter into a physician incentive plan, Managed Care Plan shall make no specific payment directly or indirectly under the physician incentive plan to Provider as an inducement to reduce or limit, Medically Necessary services to a Medicaid Enrollee, and the incentive plan(s) shall not contain provisions that provide incentives, monetary or otherwise, for withholding Medically Necessary care. Furthermore, compensation under the Agreement will not be made or structured in a manner that, directly or indirectly, effects an inducement to limit the provision of Medically Necessary services to Medicaid Enrollees. The compensation provisions under the Agreement and any subcontract hereunder do not, and will not, provide incentives, directly or indirectly, monetary or otherwise, to reduce or limit, or for the withholding of Medically Necessary medical care. Compensation paid to individuals or entities conducting utilization management activities will not be structured so as to provide incentives for the individual or entity to deny, limit or discontinue Medically Necessary services to any Medicaid Enrollee.

44. Provider shall and shall cause each member of its professional staff to allow for timely access to care for all Medicaid Enrollee appointments in accordance Managed Care Plan's guidelines and regulations.

45. To the extent applicable, Provider agrees and shall cause each member of its professional staff to agree to perform Medicaid Enrollee case management responsibilities and duties associated with its designation as a Primary Care Physician.

46. If Copayments are waived as an expanded benefit, Provider shall not charge Medicaid Enrollees Copayments for Covered Medical Services; and if Copayments are not waived as an expanded benefit, that the amount paid to Providers shall be the contracted amount, less any applicable Copayments.

47. Provider agrees that if Provider is approved by Managed Care Plan to provide services through telemedicine, then Provider is required to have and implement protocols to prevent telemedicine fraud and abuse that address:

    - Authentication and authorization of users;
    - Authentication of the origin of the information;
    - The prevention of unauthorized access to the system or information;
    - System security, including the integrity of information that is collected, program integrity and system integrity; and
    - Maintenance of documentation about system and information usage.

48. Any contracts, agreements, or subcontracts entered into by Provider for the purposes of carrying out any aspect of the Agreement or this Addendum must include assurances that the individuals who are signing the contract, agreement or subcontract are so authorized and that it includes all the requirements of the Agreement, this Addendum, and the Medicaid Contract as applicable. Provider acknowledges and agrees that if the performance of Provider or any professional staff member or the performance of their

respective subcontractors, as it relates to the Agreement, this Addendum, or the Medicaid Contract, is inadequate, Managed Care Plan shall have the right to revoke the delegation of duties and obligations under this Agreement and to, or impose other sanctions on, Provider and its professional staff. Furthermore, Provider will be obligated to revoke the delegation of duties and obligations to, or impose other sanctions on, its subcontractors at the request of Managed Care Plan.

49. Managed Care Plan shall not discriminate with respect to participation, reimbursement, or indemnification of Provider or its professional staff who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of such license or certification. This provision should not be construed as an “any willing” provider law, and it does not prohibit Managed Care Plan from limiting professional staff participation to the extent necessary to meet the needs of Medicaid Enrollees. Furthermore, this provision does not interfere with measures established by Managed Care Plan that are designed to maintain quality and control costs.

50. Provider and each member of its professional staff shall maintain complete and accurate fiscal, medical/case, social and other administrative records for medical services rendered to Medicaid Enrollees and as are necessary to document the quality, quantity, appropriateness and timeliness of services performed under the Agreement and in compliance with 42 CFR 431 & 42 CFR 456 and other applicable state and federal laws, rules and regulations and the Medicaid Contract. Provider shall and shall cause each member of its professional staff to maintain and retain said records for a period of at least ten (10) years after Managed Care Plan’s Medicaid Contract with AHCA is terminated and retained further if the records are under review or audit until the review or audit is complete. Said records will be made available for audit, review and/or other periodic monitoring upon request by Managed Care Plan, AHCA, CMS or DHHS, or their respective designees.

51. Notwithstanding anything to the contrary herein, either party may terminate the Agreement, in accordance with the terms and conditions of the Agreement, with additional notice of such termination to AHCA. Managed Care Plan shall comply with all state and federal laws regarding provider termination.

52. Managed Care Plan shall notify the provider, the Agency and enrollees in active care at least sixty (60) calendar days before the effective date of the suspension or termination of a provider from the network. If the termination was for "cause," the Managed Care Plan shall provide to the Agency the reasons for termination. The notice time does not apply in a case in which a patient's health is subject to imminent danger or a physician's ability to practice medicine is effectively impaired by an action by the Board of Medicine or other governmental agency.

53. Enrollees residing in residential facilities may be assessed for patient responsibility. Some enrollees have no patient responsibility either because of their limited income or the methodology used to determine patient responsibility. Provider, if a residential facility, agrees that the Managed Care Plan is transferring the responsibility for collecting its Enrollees’ patient responsibility when the Enrollee has a residential agreement with the Provider. Managed Care Plan will compensate the residential Provider net of the patient responsibility amount.

    The Provider’s obligations are:

- Cooperate with Department of Children and Family Services (DCF) by providing the Basic (Semi-Private) Room & Board Declaration they require to calculate the Patient Responsibility.
- When DCF issues the Patient Responsibility determination, support getting that information to the claims department as identified in the Provider Handbook.
- Collect Patient Responsibility funds from Resident / Enrollee

Managed Care Plan obligations in the collection of Patient Responsibility are:

- Care Manager: When DCF issues the Patient Responsibility determination, support getting that information to the claims department
- Claims Department: Ensure all Patient Responsibility determinations are incorporated in the claims payment process.

54. Provider shall and shall cause each member of its professional staff to provide all Covered Medical Services to populations to be served in accordance with the terms and conditions of the standards specified in the Agency's Medicaid Services Coverage & Limitations Handbooks, the Medicaid Contract, and Managed Care Plan's Provider Handbook. This includes professional licensure & certification standards for all service providers. Exceptions exist where different standards are specified elsewhere in Medicaid Contract.

55. A facilities Provider warrants it is licensed, as required by law and rule, accessible to the handicapped, in compliance with federal Americans with Disabilities Act guidelines, and has adequate space, supplies, good sanitation, and fire, safety, and disaster preparedness and recovery procedures in operation.

56. The Provider shall establish and verify criteria that includes a determination of whether the Provider or employee or volunteer of the Provider, meets the definition of a "direct service provider" and requires the completion of a Level II criminal history background to determine whether any have disqualifying offenses as provided for in s. 430.0402, F.S., and s. 435.04, F.S. Any provider or employee or volunteer of the Provider, meeting the definition of "direct service provider" who has a disqualifying offense is prohibited from providing services to enrollees.

    - No additional Level II screening is required of the provider if the provider is a Limited Enrolled or Fully Enrolled Medicaid provider.
    - No additional Level II screening is required of an employee or volunteer of the Provider who is qualified for licensure or employment by the Agency pursuant to its background screening standards under s. 408.809, F.S., and the individual is providing a service that is within the scope of his or her licensed practice or employment. (See s. 430.0402(3), F.S.).

    (1) The Managed Care Plan will require a signed affidavit from each Provider attesting to its compliance with this requirement, or with the requirements of its licensing agency if the licensing agency requires Level II screening of direct services providers.
    (2) The Managed Care Plan will verify compliance as part of its subcontractor and provider monitoring activity.

IN WITNESS WHEREOF, each party hereto represents and warrants that it has taken all necessary action to authorize entering into this Exhibit I-Florida Medicaid Addenda to Agreement and that the person executing this Addenda has the authority necessary to bind the entity identified herein and have caused this Exhibit I version to be incorporated in the Agreement with all its Parts previously executed. Any notices shall be provided to the persons and addresses listed below or at the Notice Section of the Agreement.

Independent Living Systems, LLC

By:___________________________
Nestor Plana, CEO

Date___________________________

Provider: ___________________________

Print Name: ___________________________

Date ___________________________

Address: ___________________________

Tax ID #: ___________________________

Medicaid # ___________________________

NPI ___________________________

Medicare # ___________________________

Part 5 - Programs, Rates, and Services

Program Participation

Provider agrees to participate in the Managed Care Plans and other health benefit programs/products listed in Part 6 - Program Participation Schedules attached hereto and made a part hereof. The parties may mutually agree in writing to increase or decrease the types of Covered Services made available to Enrollees and the types of Provider Services provided under this Agreement, subject to any required approval of the Payor or Government Sponsor. Nothing herein shall require that ILS Community Network identify, designate or include Provider as a preferred participant in any specific Managed Care Plan or product. Notwithstanding any other provision of this Agreement: (i) ILS Community Network reserves the right to introduce and designate Provider's participation in new Managed Care Plans and products, or terminate Provider's participation in existing Managed Care Plans and products, during the term of this Agreement by submitting notice to Provider in writing identifying the new or terminated Managed Care Plan or product and the effective date of the new addition or termination, as the case may be (a "Product Notice"); and (ii) following delivery of such Product Notice, the new or terminated Managed Care Plans and products shall be deemed included in or removed from Part 6 - Program Participation Schedules, as the case may be, as of the effective date set forth in the Product Notice. Terminating Provider from participation in a Managed Care Plan and removing such Managed Care Plan from Part 6 - Program Participation Schedules will not terminate this Agreement or its application to other, Managed Care Plans unless otherwise terminated in accordance with the terms of this Agreement.

Part 5 - Rates and Services

Provider shall provide or arrange for the provision of services in accordance with the Mandates, as and when requested by ILS Community Network or Managed Care Plan from time to time, which may include without limitation the following, as well as the services described by Payor Contract, Waiver application, Mandates, and/or your Provider license.

The Provider shall identify to ILS Community Network and the applicable Managed Care Plan if any aspect of Covered Services herein are to be subcontracted by the Provider. Provider will comply with all sections of this Agreement related to Provider subcontracting.

1. Reimbursement Rates

As compensation for the provision of Covered Services, Managed Care Plan or ILS Community Network, as applicable, shall pay Provider in accordance with the prevailing State Medicaid Fee Schedule which may be a Medicaid Waiver fee schedule if Enrollee was enrolled in such a Medicaid Waiver in the month prior to becoming a Managed Care Plan Enrollee. Any exceptions to the Medicaid fee and/or Medicaid Waiver fee schedule(s) will be identified herein but will be no less than 100% of the State Agency established rates used for the Regional Fee-For-Service "Provider Service Network".

When Medicare Covered Services are applicable, the payment to Provider will be in accordance with the prevailing Medicare Fee Schedule, with any exceptions identified herein on a Medicare fee schedule.

Provider expressly agrees to accept such compensation as payment in full for the provision of Covered Services, less any applicable Co-payments or Co-insurance or an enrollee's share of cost responsibility.

2. Compensation Terms

a. Managed Care Plan or delegee shall apply changes to the above referenced Payor fee schedule on its effective date if Payor publishes such changes at least forty-five (45) days prior to their effective date. If Payor publishes such changes less than forty-five (45) days prior to their effective date, changes will be applied prospectively to claims for dates of service no later than forty-five (45) days following their publication.

b. In the event that the rate provided herein exceeds the charges billed by Provider to Managed Care Plan or delegee, payment will be made in the amount of Provider's billed charges.

c. Managed Care Plan or ILS Community Network may supplement the Payor published fee schedule with rates it establishes should codes for Covered Services not be included in the Payor published fee schedule.

d. Should a Provider's State Medicaid rates transition from Cost Based payments to a Price Based System or otherwise change due to Mandates to reflect for example, efficiencies or quality, the Reimbursement Rates will be adjusted to conform to those Mandates.

3. Provider Services and Geographic Areas that access Provider Services

If applicable, reference most recent Attestation as Attachment-A to this Agreement.

For purposes of the Provider Directory, it is assumed that Enrollees from contingent counties could access the Provider's facility based services.

On the next page, enter the Medicaid Rate for the Applicable Services offered by Provider. Alternatively, you may also enter the word "applicable" to identify the service provided.

<u>Remainder of this Page Intentionally Left Blank</u>

PART 5: - Adult Family Care Home (AFCH) COMPENSATION and SERVICES

An ILS Provider Representative Will Contact You Shortly

Thank for your interest in joining ILS Community Network. Your local provider representative will contact you shortly to answer any questions and provide you with current rates being offered in your service area.

If you do not hear from a representative with 24-48 hours contact the ILS Provider Services department. For your convenience, you may submit your inquiry by:

EMAIL: floridaproviders@ilshealth.com
FAX: 1-888-827-6170
PHONE: 1-888-262-1292 Options 8,8,3

MAIL: **Attn: Provider Services Department**
Intendent Living System, LLC
4601 NW 77th Ave
Doral, FL 33166

PROVIDER shall render to Part 6-Participating MCO Health Plan Members the services agreed as reflected in the Resident service/care plan.

Assistive Care Services:

- Health Support Component: Observe enrollee whereabouts on a daily basis; Remind the enrollee of any important tasks on a daily basis; Record and share any significant changes in the enrollee appearance, behavior, or state of health to the health care provider, designated representative, and case manager.
- IADLs Instrumental Activities of Daily Living Component: Provide intensive assistance with one or more of the following activities: individual assistance with shopping for personal items; making telephone calls; and managing money.

Services as may be more specifically reflected on the service/care plan may include:

- Bathing: Supervision or assistance that will be secondary to such ILS contracted service by a Hospice provider or when the Hospice provider adds their bath services to the resident's interdisciplinary care plan.
- Dressing: Assist as needed;
- Personal Hygiene: Finger nails, teeth, other as needed or per care plan subject to license qualifications.
- Locomotion: Supervision or assistance
- Eating: Supervision or assistance
- Toileting: Supervision or assistance
- Medication Practices: Assistance with self-administration & other practices as anticipated by Mandates and this Agreement including Medication Administration.
- Incontinence Care: Occasional, frequent, or total incontinence, including hygiene
- Emergency Call System: ACCORDING TO EXISTING SYSTEMS OR RESIDENT CARE PLAN REQUIRMENTS;
- Teaching or Behavioral Management: Assist, encourage per care plan, license, and experience;
- Transportation for Physician appointment is not included in Capitation, but may be good practice. AFCH may provide as part of community practice or use 3rd party provider at AFCH expense or traditional Medicaid Transportation as applicable.

Patient Responsibility

Enrollees residing in residential facilities are assessed for patient responsibility by DCF and pay their patient responsibility. (Residential facilities include nursing facilities, assisted living facilities and adult family care homes.) Some enrollees have no patient responsibility either because of their limited income or the methodology used to determine patient responsibility.

The Managed Care Plan does transfer the responsibility for collecting its enrollees' patient responsibility to the residential facilities and will compensate the residential facilities net of the patient responsibility amount.

The provider and Managed Care Plan will ensure both parties have a copy of the DCF "Notice of Case Action" (NOCA) which will show the "Share of Cost" (SOC), if any. The

(page 3 of 3):

Provider will collect that SOC/Patient Responsibility amount from the member and the Plan will deduct that same SOC sum from the payment for services to the Provider.

The "Explanation of Benefit" (EOB) that accompanies the claim payment will reflect the SOC deduction. Submission of documentation required to process a claim and acceptance of the claim proceeds associated with a specific EOB will be evidence of the receipt of the patient responsibility by the Provider for that specific EOB.

The Provider shall not assess late fees for the collection of patient responsibility from enrollees.

If the **"Medicaid Pending"** applicant is approved and enrolled, the Plan will settle with the Provider based on the retroactive funding date as determined by the Florida State Agency and according to the compensation schedule applicable herein. If an individual's Medicaid eligibility is denied following a Medicaid Pending referral or Medicaid Pending status, the individual may not be referred for enrollment and/or continue to receive MCO authorized services until their Medicaid financial eligibility is approved. Provider may not seek payment from a Medicaid Pending enrollee on behalf of the Managed Care Plan.

Assisted Living Facilities (ALF) and Adult Family Care Homes (AFCH) must maintain Home-Like Environment (HLE) (aka Home and Community Based or HCB) characteristics according to Mandates. Notwithstanding anything to the contrary in this agreement, the following shall apply.

(Provider Name) ____ will support the enrollee's community inclusion and integration by working with the case manager and enrollee to facilitate the enrollee's personal goals and community activities.

Enrollees residing in (Provider Name) ____ must be offered services with the following options unless medical, physical, or cognitive impairments restrict or limit exercise of these options.

Additionally, waiver enrollees residing in assisted living facilities and other residential care facilities must be offered services with the following options unless medical, physical, or cognitive impairments restrict or limit exercise of these options.

Choice of:

- Private or semi-private rooms;
- Roommate for semi-private rooms;
- Locking door to living unit;
- Access to telephone and length of use;
- Eating schedule; and
- Participation in facility and community activities.

Ability to have:

- Unlimited visitation; and
- Snacks as desired.

Ability to:

- Prepare snacks as desired; and
- Maintain personal sleeping schedule.

The Managed Care Plan is tasked by contract with the Agency for Health Care Administration with a number of steps to ensure compliance for the benefit of the enrollee.

- On-Site verification before your services are offered to an enrollee
- Care Manager education of enrollee and 90 day face to face enrollee verification
- Documentation in the Plan of Care – a copy of which should be in your resident's file.
- Credentialing monitoring with the possibility of a corrective action plan, change in your provider status or possible disenrollment of an enrollee in the event Home and Community Based characteristics are not maintained and the enrollee will not relocate.
- .

End of Part 5

Part 6 - Program Participation Schedule

Unless "ILS Community Network" is notified otherwise in writing, Provider agrees to participate in the Managed Care Plans and other health benefit programs listed herein including:

- Those State of Florida Long Term Care Managed Care Plans and programs offered by ILS Community Network or any client Managed Care Plan of ILS pursuant to a Payor Contract within the State of Florida, and more specifically those listed below.
- Provider shall be a Participating Provider with "ILS Community Network" under the Managed Care Plan Contract and Payor Contract indicated below until Provider opts out in writing per the provisions of the Agreement:
- Facility Based Providers agree that they may be listed in ILS and the Managed Care Plan's Provider Directories for all adjacent State counties to better accommodate enrollees geographic options to access eligible services.

Managed Care Plan Contract	Payor Contract / Program
ALL PLANS	Florida Statewide Medicaid Managed Care SMMC, LTC and MMA component as applicable to provider services

Claims (delegee) and other contact information, including how Managed Care Plan handbooks sections are made available to Providers electronically, will be in the Managed Care Plan Cover Letter. Provider will acknowledge receipt of handbook(s) referenced and will agree to comply with all applicable terms and conditions contained therein. At minimum, a 30-day written notice is given for material changes to Provider Handbooks.

With the signature below, ILS attests it has completed a credentialing process that finds this Provider eligible to serve the Managed Care Plans and Programs listed above as of the date shown below. The Provider may opt out of such participation per the provisions of this Agreement. The Managed Care Plan and Payor identified are beneficiaries of this Agreement and may enforce any of its rights per the provisions of this Agreement.

Independent Living Systems, LLC

By:__________________________
Nestor Plana, CEO

Date__________________________

Provider Name

____

Date:______________________________

Address: __________________________

Tax ID #: __________________________

Medicaid # _________________________

NPI ______________________________

Medicare # _________________________

ATTACHMENTS

Service Area Attestation

Provider/Facility Name:	
Provider/Facility Address:	

I,_______________________________________(Name) hereby verify that the PROVIDER named herein is a subcontracted entity/participant in the provider network for Medicaid, Medicare, and other programs with ILS Community Network and its Affiliated Managed Care Plans, for the following service areas: (**Select applicable AHCA Region below)**

☐ 1 ☐ 2 ☐ 3 ☐ 4, ☐ 5, ☐ 6, ☐ 7, ☐ 8, ☐ 9, ☐ 10, ☐ 11 ☐ Statewide ☐ National

Specify all counties that access your services in the section provided below.
Facility based providers will be listed in Provider Directories for all adjacent state counties.

☐ Alachua	☐ Baker	☐ Bay	☐ Bradford	☐ Brevard	☐ Broward	☐ Calhoun
☐ Charlotte	☐ Citrus	☐ Clay	☐ Collier	☐ Columbia	☐ DeSoto	☐ Dixie
☐ Duval	☐ Escambia	☐ Flagler	☐ Franklin	☐ Gadsden	☐ Gilchrist	☐ Glades
☐ Gulf	☐ Hamilton	☐ Hardee	☐ Hendry	☐ Hernando	☐ Highlands	☐ Hillsborough
☐ Holmes	☐ Indian River	☐ Jackson	☐ Jefferson	☐ Lafayette	☐ Lake	☐ Lee
☐ Leon	☐ Levy	☐ Liberty	☐ Madison	☐ Manatee	☐ Marion	☐ Martin
☐ Miami-Dade	☐ Monroe	☐ Nassau	☐ Okaloosa	☐ Okeechobee	☐ Orange	☐ Osceola
☐ Palm Beach	☐ Pasco	☐ Pinellas	☐ Polk	☐ Putnam	☐ St. Lucie	☐ St. Johns
☐ Santa Rosa	☐ Sarasota	☐ Seminole	☐ Sumter	☐ Suwannee	☐ Taylor	☐ Union
☐ Volusia	☐ Wakulla	☐ Walton	☐ Washington			

PROVIDER COVERED SERVICES
I confirm that the PROVIDER/ENTITY named herein will be providing the service(s) listed below for enrollees of provider network for Medicaid, Medicare, and other programs ("PLAN") (as applicable) on behalf of the Plan. ***(Check applicable services below)***

☐ Adult Companion Services	☐ Adult Day Health Services	☐ Assisted Living Facilities	☐ Assistive Care Services
☐ Attendant Services	☐ Behavior Management	☐ Caregiver/Family/Skill Training	☐ Case Management
☐ Chore Services	☐ Consumable Medical Supplies	☐ Dental Services	☐ Home/Environmental Accessibility Adaptation
☐ Escort Services	☐ Financial Assessment/Risk Management	☐ Hearing Services	☐ Home Delivered Meals
☐ Homemaker Services	☐ Hospice	☐ Intermittent & Skilled Nursing	☐ Medical Equipment
☐ Medication Administration	☐ Medication Management	☐ Nursing Facility Care	☐ Nutrition/Risk Reduction
☐ Occupational Therapy	☐ Personal Care Services	☐ PERS (Emergency Response System)	☐ Physical Therapy
☐ Respite Care Services	☐ Respiratory Therapy	☐ Speech Therapy	☐ Vision Services
☐ Transportation	☐ Other:		

Signature X___________________________________ Date: ____________________

Abuse, Neglect, and Exploitation Training Attestation

All providers, who are mandated reporters of abuse, neglect, and exploitation, must attest that their staff has received the appropriate training. Please complete this Attestation by marking next to the applicable statement.

______ We are a mandated reporter of Abuse, Neglect, and Exploitation. Our staff has received the appropriate training and update training as applicable. We are current with this requirement.

______ We are NOT a mandated reporter of Abuse, Neglect, and Exploitation and will update this attestation should we become a mandated reporter.

Additionally, all providers and their employees with direct contact with enrollees must have completed Abuse, Neglect, and Exploitation Training. Please complete this Attestation as evidence of your compliance by marking next to the applicable statement.

______ Our license requires that we provide Abuse, Neglect, and Exploitation training to our direct care staff upon orientation and annually. We are current with this requirement.

______ Our licensure requires that we provide Abuse, Neglect, and Exploitation training to our direct care staff upon orientation only. We are current with the requirement.

______ Our license does not require Abuse, Neglect, and Exploitation Training; however our policy and procedures require our staff to have this in-service training upon orientation. We are current with this requirement.

______ Our license does not require Abuse, Neglect, and Exploitation Training and we request information or assistance to provide this annual training to our staff. We will complete this Provider Attestation again when we are current with this training requirement.

Provider Name/City/State: ____

Signature: X__________________________ Print Name & Title: _________________________

Email: ______________________________ Date: ____________________________________

First-Tier, Downstream, and Related Entity Attestation

I hereby attest that my organization has read and understands the CMS Compliance and Fraud, Waste, and Abuse (FWA) Training and agrees to abide by the laws and regulations therein upon the initial term of my contractual status and annually thereafter.

I have read and agree to comply with all of the ILS written compliance policies and procedures and Standards of Conduct, and will implement and distribute them to all employees and board members of my organization.

I, nor any employees of my organization, have not been convicted of, or charged with, a criminal offense related to health care, nor have I been listed by a federal agency as debarred, excluded or otherwise ineligible for participation in federally funded health care programs.

I agree to review the HHS OIG List of Excluded Individuals & Entities list at http://oig.hhs.gov/exclusions/exclusions_list.asp and GSA Debarment list monthly for all employees and downstream entities of my organization. I agree to immediately disclose any exclusion, or other event that makes my organization ineligible to perform work related directly or indirectly to Federal health care programs, to Independent Living Systems, LLC.

I have effectively screened my organization's governing bodies and senior leadership for conflicts of interest.

I agree to report suspected violations of any laws and regulations to Independent Living Systems, LLC. I understand that any violation of any laws and regulations is grounds for disciplinary action, up to and including termination of my contractual status. I am aware that I am protected from retaliation for False Claims Act complaints, as well as any other applicable anti-retaliation protections.

Unless otherwise noted in the space immediately below, I am not aware of any possible violations of any laws and regulations at this time.

Provider Name/City/State: ____

Signature: X__________________________ Print Name & Title: __________________________

Email: ______________________________ Date: ___________________________________

Home-Like Environment Characteristics Community Integration Assessment

(Page 1 of 2)

CMS technical guidance and State requirements, recognizes the importance of ensuring that enrollees who reside in Residential Facilities reside in Home-Like Environments (HLE) and experience community inclusion to the fullest extent possible. There is specific provider contract language on this subject.

To access Medicaid Home and Community Based funding all Residential Facility Provider must maintain a home-like environment and community integration. Indicate the HLE characteristics and the Community Integration Goal Planning below. Use the space provided to comment on any “NO” responses.

Home-Like Environments (HLE) Characteristics	
1. The unit/room should be a specific physical place that can be owned or rented by the person receiving services, and the person should have, at a minimum, the same protections from eviction that the state’s tenants have under landlord/tenant law.	☐ Yes ☐ No
2. Privacy: Units should have lockable entrance doors, with appropriate staff having keys to doors.	☐ Yes ☐ No
3. Privacy: Residents should share units only at the residents’ choice.	☐ Yes ☐ No
4. Privacy: Unless residents sharing a unit are spouses or partners, each resident should have an individual bedroom.	☐ Yes ☐ No
5. Privacy: Residents should have the freedom to furnish and decorate their living units.	☐ Yes ☐ No
6. Residents should have the freedom and support to control their own schedules and activities, and should have access to food at any time.	☐ Yes ☐ No
7. Residents should be able to have visitors of their choosing at any time.	☐ Yes ☐ No

Comment on any NO answers:

Community Integration Goal Planning Documentation	
1. Are identified goals documented in the care plan in resident file?	☐ Yes ☐ No
2. Are identified barriers documented in the care plan in resident file?	☐ Yes ☐ No
3. Are interventions documented in the care plan in resident file?	☐ Yes ☐ No
4. Is progress documented in the care plan in resident file?	☐ Yes ☐ No

Comment on any NO answers:

[Attestation and signature on following page]

Home-Like Environment Characteristics Community Integration Attestation

(Page 2 of 2)

I ________________________________ (Name) attest, acknowledge, and agree that we are, and will maintain, compliance with the agreement language on Home-Like Environment characteristics, Community Integration, and the applicable Resident Bill of Rights.

Provider Name/City/State: ____

Signature: X_______________________ Print Name & Title: ______________________

Email Address: ______________________________ Date ______/_____/_________

Code of Ethics Acknowledgement of Receipt

ACKNOWLEDGEMENT FOR FDRS CODE OF ETHICS ASSESSMENT, ACKNOWLEDGEMENT FORMS, FAQ TRAINING AND RECEIPT OF CODE OF ETHICS SUPPORTING DOCUMENTATION

I,________________________ *(Name)* acknowledge the receipt of the ILS Code of Ethics Training, completion of the Providers and Subcontractors Assessment, and a copy of the ILS Code of Ethics for FDR. I understand the ILS Code of Ethics and agree to comply with the requirements. I understand that my failure to comply with the requirements of the ILS Code of Ethics may subject me to disciplinary action which may include termination of the business relationship.

Print Name & Title: ______________________ Signature: ____________________

Email Address: _____________________________ Date ______/_____/_________

Provider Manual Acknowledgement Form

Document Owner(s)			Project/Organization Role
Independent Living Systems, LLC "ILS"			ILS is Network of Providers and sub-contractor
THE PLAN NAMED IN PARTICIPATION ADDENDA			ILS Community Network and ALL PLANS
Version	**Date**	**Author**	**Change Description**
5	2016-2017	ILS	SMMC LTC, MMA, PSN additional requirements

Note: Contents of the provider manual does not constitute nor should it be construed as a promise of Provider status or as a contract between **the PLAN** or Independent Living Systems, LLC and any of its Providers.

The PLAN, or Independent Living Systems, LLC at its option, may change, delete, suspend, or discontinue parts or the Provider manual in its entirety, at any time without prior notice.

Provider Manual may be available at the respective web site or by contacting

Independent Living Systems, LLC "ILS"
Network Provider Credentialing & Contracting
4601 NW 77th Ave
Doral, FL 33166

Phone: (305) 262-1292 (888) 262-1292 Option 8 Option 8, Option 3
Fax: (888) 827-6170
Email FloridaProviders@ilshealth.com
Website www.ilshealth.com/providers

PLAN Grievance Coordinator

See the PLAN (TO BE ANNOUNCED) Cover letter for details with Name, Telephone Number, Address, and Office Hours.

Claims Mailing Address: **The PLAN** (TO BE ANNOUNCED) c/o ILS
See the ILS Cover letter for details

PLAN Contacts

Program Administrator: See the PLAN (TO BE ANNOUNCED) Cover letter for details
Care Manager Offices: See the PLAN (TO BE ANNOUNCED) Cover letter for details
Other relevant information: See the PLAN (TO BE ANNOUNCED) Cover letter for details

Print Name & Title: ________________________ Signature: ______________________

Email Address: ________________________________ Date ______/_____/_________