PARTICIPATING PROVIDER AGREEMENT

This Participating Provider Agreement (together with all Attachments and amendments, this "***Agreement***") is made and entered by and between Test Agreement ("***Provider***") and Delaware First Health, Inc. ("***Health Plan***") (each a "***Party***" and collectively the "***Parties***"). This Agreement is effective as of the date designated by Health Plan on the signature page of this Agreement ("***Effective Date***").

WHEREAS, Provider desires to provide certain health care services to individuals in products offered by or available from or through a Company or Payor (as hereafter defined), and Provider desires to participate in such products as a Participating Provider (as defined herein), all as hereinafter set forth.

WHEREAS, Health Plan desires for Provider to provide such health care services to individuals in such products, and Health Plan desires to have Provider participate in certain of such products as a Participating Provider, all as hereinafter set forth.

NOW, THEREFORE, in consideration of the recitals and mutual promises herein stated, the Parties hereby agree to the provisions set forth below.

ARTICLE I - DEFINITIONS

When appearing with initial capital letters in this Agreement (including an Attachment(s)), the following quoted and underlined terms (and the plural thereof, when appropriate) have the meanings set forth below.

1.1. "Affiliate" means a person or entity directly or indirectly controlling, controlled by, or under common control with Health Plan.

1.2. "Attachment" means any document, including an addendum, schedule or exhibit, attached to this Agreement as of the Effective Date or that becomes attached pursuant to Section 2.2 or Section 8.7, all of which are incorporated herein by reference and may be amended from time to time as provided in this Agreement.

1.3. "Clean Claim" has, as to each particular Product, the meaning set forth in the applicable Product Attachment or, if no such definition exists, the Provider Manual.

1.4. "Company" means (collectively or individually, as appropriate in the context) Health Plan and/or one or more of its Affiliates, except those specifically excluded by Health Plan.

1.5. "Compensation Schedule" means at any given time the then effective schedule(s) of maximum rates applicable to a particular Product under which Provider and Contracted Providers will be compensated for the provision of Covered Services to Covered Persons. Such Compensation Schedule(s) will be set forth or described in one or more Attachments to this Agreement, and may be included within a Product Attachment.

1.6. "Contracted Provider" means a physician, hospital, health care professional or any other provider of items or services that is employed by or has a contractual relationship with Provider and that provides Covered Services. The term "Contracted Provider" includes Provider for those Covered Services provided by Provider.

1.7. "Coverage Agreement" means any agreement, program or certificate entered into, issued or agreed to by Company or Payor, under which Company or Payor furnishes administrative services or other services in support of a health care program for an individual or group of individuals, and which may include access to one or more of Company's provider networks or vendor arrangements, except those excluded by Health Plan.

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

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

1.10. "Medically Necessary" or "Medical Necessity" shall have the meaning defined in the applicable Coverage Agreement or applicable Regulatory Requirements.

1.11. "Participating Provider" means, with respect to a particular Product, any physician, hospital, ancillary, or other health care provider that has contracted, directly or indirectly, with Health Plan to provide Covered Services to Covered Persons, that has been approved for participation by Company, and that is designated by Company as a "participating provider" in such Product.

1.12. "Payor" means the entity (including Company where applicable) that bears direct financial responsibility for paying from its own funds, without reimbursement from another entity, the cost of Covered Services rendered to Covered Persons under a Coverage Agreement and, if such entity is not Company, such entity contracts, directly or indirectly, with Company for the provision of certain administrative or other services with respect to such Coverage Agreement.

1.13. "Payor Contract" means the contract with a Payor, pursuant to which Company furnishes administrative services or other services in support of the Coverage Agreements entered into, issued or agreed to by a Payor, which services may include access to one or more of Company's provider networks or vendor arrangements, except those excluded by Health Plan. The term "Payor Contract" includes Company's or other Payor's contract with a governmental authority (also referred to herein as a "Governmental Contract") under which Company or Payor arranges for the provision of Covered Services to Covered Persons.

1.14. "Product" means any program or health benefit arrangement designated as a "product" by Health Plan (e.g., Health Plan Product, Medicaid Product, PPO Product, Payor-specific Product, etc.) that is now or hereafter offered by or available from or through Company (and includes the Coverage Agreements that access, or are issued or entered into in connection with such product, except those excluded by Health Plan).

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

1.16. "Provider Manual" means the provider manual and any billing manuals, adopted by Company or Payor which include, without limitation, requirements relating to utilization management, quality management, grievances and appeals, and Product-specific, Payor-specific and State-specific requirements, as may be amended from time to time by Company or Payor.

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

1.18. "State" is defined as the state identified in the applicable Attachment.

ARTICLE II - PRODUCTS AND SERVICES

2.1. Contracted Providers. Provider shall, and shall cause each Contracted Provider, to comply with and abide by the agreements, representations, warranties, acknowledgements, certifications, terms and conditions of this Agreement (including the provisions of Schedule A that are applicable to Provider, a Contracted Provider, or their services, and any other Attachments), and the Provider Manual, and fulfill all of the duties, responsibilities and obligations imposed on Provider and Contracted Providers under this Agreement (including each Attachment), and the Provider Manual.

2.2. Participation in Products. Subject to the other provisions of this Agreement, each Contracted Provider may be identified as a Participating Provider in each Product identified in a Product Attachment designated on Schedule B of this Agreement or added to this Agreement in accordance with Section 2.2 hereof.

2.2.1. Provider shall, at all times during the term of this Agreement, require each of its Contracted Providers to, subject to Company's approval, participate as Participating Providers in each Product identified in a Product Attachment that is designated on Schedule B to this Agreement or added to this Agreement in accordance with Section 2.2 hereof.

2.2.2. A Contracted Provider may only identify itself as a Participating Provider for those Products in which the Contracted Provider actually participates as provided in this Agreement. Provider acknowledges that Company or Payor may have, develop or contract to develop various Products or provider networks that have a variety of provider panels, program components and other requirements. No Company or Payor warrants or guarantees that any Contracted Provider: (i) will participate in all or a minimum number of provider panels, (ii) will be utilized by a minimum number of Covered Persons, or (iii) will indefinitely remain a Participating Provider or member of the provider panel for a particular network or Product.

2.2.3. Provider shall provide Health Plan with the information listed on Schedule C entitled "Information for Contracted Providers" for itself and the Contracted Providers as of the Effective Date. Provider shall provide Health Plan, from time to time or on a periodic basis as requested by Health Plan, with a complete and accurate list of Information for Contracted Providers and such other information as mutually agreed upon by the Parties, and shall provide Health Plan with a list of modifications to such list at least 30 days prior to the effective date of such changes, when possible. Provider shall provide such lists in a manner and format mutually acceptable to the Parties.

2.2.4. Provider may add new providers to this Agreement as Contracted Providers. In such case, Provider shall provide written notice to Health Plan of the prospective addition(s), and shall use best efforts to provide such notice at least 60 days in advance of such addition. Provider shall maintain written agreements with each of its Contracted Providers (other than Provider) that require the Contracted Providers to comply with the terms and conditions of this Agreement and that address and comply with the Regulatory Requirements.

2.2.5. If Company desires to add one or more Contracted Providers to an additional Product, Company or Payor, as applicable, will provide advance written notice (electronic or paper) thereof to Provider, along with the applicable Product Attachment and the new Compensation Schedule, if any. The applicable Contracted Providers will not be designated as Participating Providers in such additional Product if Provider opts out of such additional Product by giving Company or Payor, as applicable, written notice of its decision to opt-out within 30 days of Company's or Payor's, as applicable, giving of written notice. If Provider timely provides such opt-out notice, the applicable Contracted Providers will not be considered Participating Providers in such Product. If Provider does not timely provide such opt-out notice, then each applicable Contracted Provider shall be a Participating Provider in such additional Product on the terms and conditions set forth in this Agreement and the applicable Product Attachment.

2.3. Covered Services. Each Contracted Provider shall provide Covered Services described or referenced in the applicable Product Attachment(s) to Covered Persons in those Products in which the Contracted Provider is a

Participating Provider, in accordance with this Agreement. Each Contracted Provider shall provide Covered Services to Covered Persons with the same degree of care and skill as customarily provided to patients who are not Covered Persons, within the scope of the Contracted Provider's license and in accordance with generally accepted standards of the Contracted Provider's practice and business and in accordance with the provisions of this Agreement, the Provider Manual, and Regulatory Requirements.

2.4. Provider Manual; Policies and Procedures. Provider and Contracted Providers shall at all times cooperate and comply with the requirements, policies, programs and procedures ("Policies") of Company and Payor, which may be described in the Provider Manual and include, but are not limited to, the following: credentialing criteria and requirements; notification requirements; medical management programs; claims and billing, quality assessment and improvement, utilization review and management, disease management, case management, on-site reviews, referral and prior authorization, and grievance and appeal procedures; coordination of benefits and third party liability policies; carve-out and third party vendor programs; and data reporting requirements. The failure to comply with such Policies could result in a denial or reduction of payment to the Provider or Contracted Provider or a denial or reduction of the Covered Person's benefits. Such Policies do not in any way affect or remove the obligation of Contracted Providers to render care. Health Plan shall make the Provider Manual available to Provider and Contracted Providers via one or more designated websites or alternative means. Upon Provider's reasonable request, Health Plan shall provide Provider with a copy of the Provider Manual. In the event of a material change to the Provider Manual, Health Plan will use reasonable efforts to notify Provider in advance of such change. Such notice may be given by Health Plan through a periodic provider newsletter, an update to the on-line Provider Manual, or any other written method (electronic or paper).

2.5. Credentialing Criteria. Provider and each Contracted Provider shall complete Company's and/or Payor's credentialing and/or recredentialing process as required by Company's and/or Payor's credentialing Policies, and shall at all times during the term of this Agreement meet all of Company's and/or Payor's credentialing criteria. Provider and each Contracted Provider represents, warrants and agrees: (a) that it is currently, and for the duration of this Agreement shall remain: (i) in compliance with all applicable Regulatory Requirements, including licensing laws; (ii) if applicable, accredited by The Joint Commission or the American Osteopathic Association; and (iii) a Medicare participating provider under the federal Medicare program and a Medicaid participating provider under applicable federal and State laws; and (b) that all Contracted Providers and all employees and contractors thereof will perform their duties in accordance with all Regulatory Requirements, as well as applicable national, State and local standards of professional ethics and practice. No Contracted Provider shall provide Covered Services to Covered Persons or identify itself as a Participating Provider unless and until the Contracted Provider has been notified, in writing, by Company that such Contracted Provider has successfully completed Company's credentialing process.

2.6. Eligibility Determinations. Provider or Contracted Provider shall timely verify whether an individual seeking Covered Services is a Covered Person. Company or Payor, as applicable, will make available to Provider and Contracted Providers a method, whereby Provider and Contracted Providers can obtain, in a timely manner, general information about eligibility and coverage. Company or Payor, as applicable, does not guarantee that persons identified as Covered Persons are eligible for benefits or that all services or supplies are Covered Services. If Company, Payor or its delegate determines that an individual was not a Covered Person at the time services were rendered, such services shall not be eligible for payment under this Agreement. In addition, Company will use reasonable efforts to include or contractually require Payors to clearly display Company's name, logo or mailing address (or other identifier(s) designated from time to time by Company) on each membership card.

2.7. Referral and Preauthorization Procedures. Provider and Contracted Providers shall comply with referral and preauthorization procedures adopted by Company and or Payor, as applicable, prior to referring a Covered Person to any individual, institutional or ancillary health care provider. Unless otherwise expressly authorized in writing by Company or Payor, Provider and Contracted Providers shall refer Covered Persons only to Participating Providers to provide the Covered Service for which the Covered Person is referred. Except as required by applicable law, failure of Provider and Contracted Providers to follow such procedures may result in denial of payment for unauthorized treatment.

2.8. Treatment Decisions. No Company or Payor is liable for, nor will it exercise control over, the manner or method by which a Contracted Provider provides items or services under this Agreement. Provider and Contracted Providers understand that determinations of Company or Payor that certain items or services are not Covered Services or have not been provided or billed in accordance with the requirements of this Agreement or the Provider Manual are administrative decisions only. Such decisions do not absolve the Contracted Provider of its responsibility to exercise independent judgment in treatment decisions relating to Covered Persons. Nothing in this Agreement (i) is intended to interfere with Contracted Provider's relationship with Covered Persons, or (ii) prohibits or restricts a Contracted Provider from disclosing to any Covered Person any information that the Contracted Provider deems appropriate regarding health care quality, medical treatment decisions or alternatives.

2.9. Carve-Out Vendors. Provider acknowledges that Company may, during the term of this Agreement, carve-out certain Covered Services from its general provider contracts, including this Agreement, for one or more Products as Company deems necessary or appropriate. Provider and Contracted Providers shall cooperate with and, when medically appropriate, utilize all third party vendors designated by Company for those Covered Services identified by Company from time to time for a particular Product.

2.10. Disparagement Prohibition. Provider, each Contracted Provider and the officers of Company shall not disparage the other during the term of this Agreement or in connection with any expiration, termination or non-renewal of this Agreement. Neither Provider nor Contracted Provider shall interfere with Company's direct or indirect contractual relationships including, but not limited to, those with Covered Persons or other Participating Providers. Nothing in this Agreement should be construed as limiting the ability of either Health Plan, Company, Provider or a Contracted Provider to inform Covered Persons that this Agreement has been terminated or otherwise expired or, with respect to Provider, to promote Provider to the general public or to post information regarding other health plans consistent with Provider's usual procedures, provided that no such promotion or advertisement is specifically directed at one or more Covered Persons. In addition, nothing in this provision should be construed as limiting Company's ability to use and disclose information and data obtained from or about Provider or Contracted Provider, including this Agreement, to the extent determined reasonably necessary or appropriate by Company in connection with its efforts to comply with Regulatory Requirements and to communicate with regulatory authorities.

2.11. Nondiscrimination. Provider and each Contracted Provider will provide Covered Services to Covered Persons without discrimination on account of race, sex, sexual orientation, age, color, religion, national origin, place of residence, health status, type of Payor, source of payment (e.g., Medicaid generally or a State-specific health care program), physical or mental disability or veteran status, and will ensure that its facilities are accessible as required by Title III of the Americans With Disabilities Act of 1991. Provider and Contracted Providers recognize that, as a governmental contractor, Company or Payor may be subject to various federal laws, executive orders and regulations regarding equal opportunity and affirmative action, which also may be applicable to subcontractors, and Provider and each Contracted Provider agree to comply with such requirements as described in any applicable Attachment.

2.12. Notice of Certain Events. Provider shall give written notice to Health Plan of: (i) any event of which notice must be given to a licensing or accreditation agency or board; (ii) any change in the status of Provider's or a Contracted Provider's license; (iii) termination, suspension, exclusion or voluntary withdrawal of Provider or a Contracted Provider from any state or federal health care program, including but not limited to Medicaid; or (iv) any settlements or judgments in connection with a lawsuit or claim filed or asserted against Provider or a Contracted Provider alleging professional malpractice involving a Covered Person. In any instance described in subsection (i)-(iii) above, Provider must notify Health Plan or Payor in writing within 10 days, and in any instance described in subsection (iv) above, Provider must notify Health Plan or Payor in writing within 30 days, from the date it first obtains knowledge of the pending of the same.

2.13. Use of Name. Provider and each Contracted Provider hereby authorizes each Company or Payor to use their respective names, telephone numbers, addresses, specialties, certifications, hospital affiliations (if any), and

other descriptive characteristics of their facilities, practices and services for the purpose of identifying the Contracted Providers as "Participating Providers" in the applicable Products. Provider and Contracted Providers may only use the name of the applicable Company or Payor for purposes of identifying the Products in which they participate, and may not use the registered trademark or service mark of Company or Payor without prior written consent.

2.14. Compliance with Regulatory Requirements. Provider, each Contracted Provider and Company agree to carry out their respective obligations under this Agreement and the Provider Manual in accordance with all applicable Regulatory Requirements, including, but not limited to, the requirements of the Health Insurance Portability and Accountability Act, as amended, and any regulations promulgated thereunder. If, due to Provider's or Contracted Provider's noncompliance with applicable Regulatory Requirements or this Agreement, sanctions or penalties are imposed on Company, Company may, in its sole discretion, offset such amounts against any amounts due Provider or Contracted Providers from any Company or require Provider or the Contracted Provider to reimburse Company for such amounts.

2.15. Program Integrity Required Disclosures. Provider agrees to furnish to Health Plan complete and accurate information necessary to permit Company to comply with the collection of disclosures requirements specified in 42 C.F.R. Part 455 Subpart B or any other applicable State or federal requirements, within such time period as is necessary to permit Company to comply with such requirements. Such requirements include but are not limited to: (i) 42 C.F.R. §455.105, relating to (a) the ownership of any subcontractor with whom Provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request and (b) any significant business transaction between Provider and any wholly owned supplier or subcontractor during the 5 year period ending on the date of the request; (ii) 42 C.F.R. §455.104, relating to individuals or entities with an ownership or controlling interest in Provider; and (iii) 42 C.F.R. §455.106, relating to individuals with an ownership or controlling interest in Provider, or who are managing employees of Provider, who have been convicted of a crime.

ARTICLE III - CLAIMS SUBMISSION, PROCESSING, AND COMPENSATION

3.1. Claims or Encounter Data Submission. As provided in the Provider Manual and/or Policies, Contracted Providers shall submit to Payor or its delegate claims for payment for Covered Services rendered to Covered Persons. Contracted Provider shall submit encounter data to Payor or its delegate in a timely fashion, which must contain statistical and descriptive medical and patient data and identifying information, if and as required in the Provider Manual. Payor or its delegate reserves the right to deny payment to the Contracted Provider if the Contracted Provider fails to submit claims for payment or encounter data in accordance with the Provider Manual and/or Policies.

3.2. Compensation. The compensation for Covered Services provided to a Covered Person ("Compensation Amount") will be the appropriate amount under the applicable Compensation Schedule in effect on the date of service for the Product in which the Covered Person participates. Subject to the terms of this Agreement and the Provider Manual, Provider and Contracted Providers shall accept the Compensation Amount as payment in full for the provision of Covered Services. Subject to the terms of this Agreement, Payor shall pay or arrange for payment of each Clean Claim received from a Contracted Provider for Covered Services provided to a Covered Person in accordance with the applicable Compensation Amount less any applicable copayments, cost-sharing or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement.

3.3. Financial Incentives. The Parties acknowledge and agree that nothing in this Agreement shall be construed to create any financial incentive for Provider or a Contracted Provider to withhold Covered Services.

3.4. Hold Harmless. Provider and each Contracted Provider agree that in no event, including but not limited to non-payment by a Payor, a Payor's insolvency, or breach of this Agreement, shall Provider or a Contracted Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Covered Person or person acting on the Covered Person's behalf, other than Payor, for Covered Services provided under this Agreement. This provision shall not prohibit collection of any applicable copayments, cost-sharing or other amounts that are the Covered Person's financial responsibility under the applicable Coverage

Agreement. This provision survives termination or expiration of this Agreement for any reason, will be construed for the benefit of Covered Persons, and supersedes any oral or written agreement entered into between Provider or a Contracted Provider and a Covered Person.

3.5. Recovery Rights. Payor or its delegate shall have the right to immediately offset or recoup any and all amounts owed by Provider or a Contracted Provider to Payor or Company against amounts owed by the Payor or Company to the Provider or Contracted Provider. Provider and Contracted Providers agree that all recoupment and any offset rights under this Agreement will constitute rights of recoupment authorized under State or federal law and that such rights will not be subject to any requirement of prior or other approval from any court or other government authority that may now have or hereafter have jurisdiction over Provider or a Contracted Provider.

ARTICLE IV - RECORDS AND INSPECTIONS

4.1. Records. Each Contracted Provider shall maintain medical, financial and administrative records related to items or services provided to Covered Persons, including but not limited to a complete and accurate permanent medical record for each such Covered Person, in such form and detail as are required by applicable Regulatory Requirements and consistent with generally accepted medical standards.

4.2. Access. Provider and each Contracted Provider shall provide access to their respective books and records to each of the following, including any delegate or duly authorized agent thereof, subject to applicable Regulatory Requirements: (i) Company and Payor, during regular business hours and upon prior notice; (ii) appropriate State and federal authorities, to the extent such access is necessary to comply with Regulatory Requirements; and (iii) accreditation organizations. Provider and each Contracted Provider shall provide copies of such records at no expense to any of the foregoing that may make such request. Each Contracted Provider also shall obtain any authorization or consent that may be required from a Covered Person in order to release medical records and information to Company or Payor or any of their delegates. Provider and each Contracted Provider shall cooperate in and allow on-site inspections of its, his or her facilities and records by any Company, Payor, their delegates, any authorized government officials, and accreditation organizations. Provider and each Contracted Provider shall compile information necessary for the expeditious completion of such on-site inspection in a timely manner.

4.3. Record Transfer. Subject to applicable Regulatory Requirements, each Contracted Provider shall cooperate in the timely transfer of Covered Persons' medical records to any other health care provider, at no charge and when required.

ARTICLE V - INSURANCE AND INDEMNIFICATION

5.1. Insurance. During the term of this Agreement and for any applicable continuation period as set forth in Section 7.3 of this Agreement, Provider and/or each Contracted Provider shall maintain policies of general and professional liability insurance and other insurance necessary to insure Provider and such Contracted Provider, respectively; their respective employees; and any other person providing services hereunder on behalf of Provider or such Contracted Provider, as applicable, against any claim(s) of personal injuries or death alleged to have been caused or caused by their performance under this Agreement. Such insurance shall include, but not be limited to, any "tail" or prior acts coverage necessary to avoid any gap in coverage. Insurance shall be through a licensed carrier acceptable to Health Plan, and in a minimum amount of $1,000,000 per occurrence, and $3,000,000 in the aggregate unless a lesser amount is accepted by Health Plan or where State law mandates otherwise. Provider and/or each Contracted Provider will provide Health Plan with at least 10 days prior written notice of cancellation, non-renewal, lapse, or adverse material modification of such coverage. Upon Health Plan's request, Provider and each Contracted Provider will furnish Health Plan with evidence of such insurance.

5.2. Indemnification by Provider and Contracted Provider. Provider and each Contracted Provider shall indemnify and hold harmless (and at Health Plan's request defend) Company and Payor and all of their respective

officers, directors, agents and employees from and against any and all third party claims for any loss, damages, liability, costs, or expenses (including reasonable attorney's fees) judgments or obligations arising from or relating to any negligence, wrongful act or omission, or breach of this Agreement by Provider, a Contracted Provider, or any of their respective officers, directors, agents or employees.

5.3. Indemnification by Health Plan. Health Plan agrees to indemnify and hold harmless (and at Provider's request defend) Provider, Contracted Providers, and their officers, directors, agents and employees from and against any and all third party claims for any loss, damages, liability, costs, or expenses (including reasonable attorney's fees), judgments, or obligations arising from or relating to any negligence, wrongful act or omission or breach of this Agreement by Company or its directors, officers, agents or employees.

ARTICLE VI - DISPUTE RESOLUTION

6.1. Informal Dispute Resolution. Any dispute between Provider and/or a Contracted Provider, as applicable (the "Provider Party"), and Health Plan and/or Company, as applicable (including any Company acting as Payor) (the "Administrator Party"), with respect to or involving the performance under, termination of, or interpretation of this Agreement, or any other claim or cause of action hereunder, whether sounding in tort, contract or under statute (a "Dispute") shall first be addressed by exhausting the applicable procedures in the Provider Manual pertaining to claims payment, credentialing, utilization management, or other programs. If, at the conclusion of these applicable procedures, the matter is not resolved to satisfaction of the Provider Party and the Administrator Party, or if there are no applicable procedures in the Provider Manual, then the Provider Party and the Administrator Party shall engage in a period of good faith negotiations between their designated representatives who have authority to settle the Dispute, which negotiations may be initiated by either the Provider Party or the Administrator Party upon written request to the other, provided such request takes place within one year of the date on which the requesting party first had, or reasonably should have had, knowledge of the event(s) giving rise to the Dispute. If the matter has not been resolved within 60 days of such request, either the Provider Party or the Administrator Party may, as its sole and exclusive forum for the litigation of the Dispute or any part thereof, initiate arbitration pursuant to Section 6.2 below by providing written notice to the other party.

6.2. Arbitration. If either the Provider Party or the Administrator Party wishes to pursue the Dispute as provided in Section 6.1, such party shall submit it to binding arbitration conducted in accordance with the Commercial Arbitration Rules of the American Arbitration Association ("AAA"). In no event may any arbitration be initiated more than 1 year following, as applicable, the end of the 60 day negotiation period set forth in Section 6.1, or the date of notice of termination. Arbitration proceedings shall be conducted by an arbitrator chosen from the National Healthcare Panel at a mutually agreed upon location within the State. The arbitrator shall not award any punitive or exemplary damages of any kind, shall not vary or ignore the provisions of this Agreement, and shall be bound by controlling law. Any arbitration in which the total amount in controversy is less than $100,000 shall be conducted in a single hearing day. The Parties and the Contracted Providers, on behalf of themselves and those that they may now or hereafter represent, agree to and do hereby waive any right to pursue, on a class basis, any Dispute. Each of the Provider Party and the Administrator Party shall bear its own costs and attorneys' fees related to the arbitration except that the AAA's Administrative Fees, all Arbitrator Compensation and travel and other expenses, and all costs of any proof produced at the direct request of the arbitrator shall be borne equally by the applicable parties, and the arbitrator shall not have the authority to order otherwise. The existence of a Dispute or arbitration proceeding shall not in and of itself constitute cause for termination of this Agreement. Except as hereafter provided, during an arbitration proceeding, each of the Provider Party and the Administrator Party shall continue to perform its obligations under this Agreement pending the decision of the arbitrator. Nothing herein shall bar either the Provider Party or the Administrator Party from seeking emergency injunctive relief to preclude any actual or perceived breach of this Agreement, although such party shall be obligated to file and pursue arbitration at the earliest reasonable opportunity. Judgment on the award rendered may be entered in any court having jurisdiction thereof. Because of the confidential nature of this Agreement, the Provider and Administrator Parties further agree that in any action to compel arbitration or enforce any arbitration award, no party may file any part of this Agreement (including Attachments) in the court

record, except this Section 6.2. Nothing contained in this Article VI shall limit a Party's right to terminate this Agreement with or without cause in accordance with Section 7.2.

ARTICLE VII - TERM AND TERMINATION

7.1. Term. This Agreement is effective as of the Health Plan Effective Date, and will remain in effect for an initial term ("Initial Term") of 3 year(s), after which it will automatically renew for successive terms of 1 year each (each a "Renewal Term"), unless this Agreement is sooner terminated as provided in this Agreement or either Party gives the other Party written notice of non-renewal of this Agreement not less than 180 days prior to the end of the then-current term. In addition, either Party may elect to not renew a Contracted Provider's participation as a Participating Provider in a particular Product for the next Renewal Term, by giving Provider written notice of such non-renewal not less than 180 days prior to the, as applicable, last day of the Initial Term or applicable Renewal Term; in such event, Provider shall immediately notify the affected Contracted Provider of such non-renewal. Termination of any Contracted Provider's participation in a particular Product will not have the effect of terminating either this Agreement or the Contracted Provider's participation in any other Product in which the Contract Provider participates under this Agreement.

7.2. Termination. This Agreement, or the participation of Provider or a Contracted Provider as a Participating Provider in one or more Products, may be terminated or suspended as set forth below.

7.2.1. Upon Notice. This Agreement may be terminated by either Party giving the other Party at least 180 days prior written notice of such termination. The participation of any Contracted Provider as a Participating Provider in a Product may be terminated by either Party giving the other Party at least 180 days prior written notice of such termination; in such event, Provider shall immediately notify the affected Contracted Provider of such termination.

7.2.2. With Cause. This Agreement, or the participation of any Contracted Provider as a Participating Provider in one or more Products under this Agreement, may be terminated by either Party giving at least 90 days prior written notice of termination to the other Party if such other Party (or the applicable Contracted Provider) is in breach of any material term or condition of this Agreement and such other Party (or the Contracted Provider) fails to cure the breach within the 60 day period immediately following the giving of written notice of such breach. Any notice given pursuant to this Section 7.2.2 must describe the specific breach. In the case of a termination of a Contracted Provider, Provider shall immediately notify the affected Contracted Provider of such termination.

7.2.3. Suspension of Participation. Unless expressly prohibited by applicable Regulatory Requirements, Health Plan has the right to immediately suspend or terminate the participation of a Contracted Provider in any or all Products by giving written notice thereof to Provider when Health Plan determines that (i) based upon available information, the continued participation of the Contracted Provider appears to constitute an immediate threat or risk to the health, safety or welfare of Covered Persons, or (ii) the Contracted Provider's fraud, malfeasance or non-compliance with Regulatory Requirements is reasonably suspected. Provider shall immediately notify the affected Contracted Provider of such suspension. During such suspension, the Contracted Provider shall, as directed by Health Plan, discontinue the provision of all or a particular Covered Service to Covered Persons. During the term of any suspension, the Contracted Provider shall notify Covered Persons that his or her status as a Participating Provider has been suspended. Such suspension will continue until the Contracted Provider's participation is reinstated or terminated.

7.2.4. Insolvency. This Agreement may be terminated immediately by a Party giving written notice thereof to the other Party if the other Party is insolvent or has bankruptcy proceedings initiated against it.

7.2.5. Credentialing. The status of a Contracted Provider as a Participating Provider in one or more Products may be terminated immediately by Health Plan giving written notice thereof to Provider if the Contracted Provider fails to adhere to Health Plan's credentialing criteria, including, but not limited to, if the Contracted Provider

(i) loses, relinquishes, or has materially affected its license to provide Covered Services in the State, (ii) fails to comply with the insurance requirements set forth in this Agreement; or (iii) is convicted of a criminal offense related to involvement in any state or federal health care program or has been terminated, suspended, barred, voluntarily withdrawn as part of a settlement agreement, or otherwise excluded from any state or federal health care program. Provider shall immediately notify the affected Contracted Provider of such termination.

7.3. Effect of Termination. After the effective date of termination of this Agreement or a Contracted Provider's participation in a Product, this Agreement shall remain in effect for purposes of those obligations and rights arising prior to the effective date of termination. Upon such a termination, each affected Contracted Provider (including Provider, if applicable) shall (i) continue to provide Covered Services to Covered Persons in the applicable Product(s) during the longer of the 90 day period following the date of such termination or such other period as may be required under any Regulatory Requirements, and, if requested by Company, each affected Contracted Provider (including Provider, if applicable) shall continue to provide, as a Participating Provider, Covered Services to Covered Persons until such Covered Persons are assigned or transferred to another Participating Provider in the applicable Product(s), and (ii) continue to comply with and abide by all of the applicable terms and conditions of this Agreement, including, but not limited to, Section 3.4 (Hold Harmless) hereof, in connection with the provision of such Covered Services during such continuation period. During such continuation period, each affected Contracted Provider (including Provider, if applicable) will be compensated in accordance with this Agreement and shall accept such compensation as payment in full.

7.4. Survival of Obligations. All provisions hereof that by their nature are to be performed or complied with following the expiration or termination of this Agreement, including without limitation Sections 2.8, 2.10, 3.2, 3.4, 3.5, 4.2, 5.1, 5.2, 5.3, 6.2, 7.3, and 7.4 and Article VIII, survive the expiration or termination of this Agreement.

ARTICLE VIII - MISCELLANEOUS

8.1. Relationship of Parties. The relationship between or among Health Plan, Company, Provider, Payor and any Contracted Provider hereunder is that of independent contractors. None of the provisions of this Agreement will be construed as creating any agency, partnership, joint venture, employee-employer, or other relationship. References herein to the rights and obligations of any Company under this Agreement are references to the rights and obligations of each Company individually and not collectively. A Company is only responsible for performing its respective obligations hereunder with respect to a particular Product, Coverage Agreement, Payor Contract, Covered Service or Covered Person. A breach or default by an individual Company shall not constitute a breach or default by any other Company, including but not limited to Health Plan.

8.2. Conflicts Between Certain Documents. If there is any conflict between this Agreement and the Provider Manual, this Agreement will control. In the event of any conflict between this Agreement and any Product Attachment, the Product Attachment will control as to such Product.

8.3. Assignment. This Agreement is intended to secure the services of and be personal to Provider and may not be assigned, sublet, delegated, subcontracted or transferred by Provider without Health Plan's prior written consent. Health Plan shall have the right, exercisable in its sole discretion, to assign or transfer all or any portion of its rights or to delegate all or any portion of its interests under this Agreement or any Attachment to an Affiliate, successor of Health Plan, or purchaser of the assets or stock of Health Plan, or the line of business or business unit primarily responsible for carrying out Health Plan's obligations under this Agreement.

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

8.5. Governing Law. The interpretation of this Agreement and the rights and obligations of Health Plan, Company, Provider and any Contracted Providers hereunder will be governed by and construed in accordance with applicable federal and State laws.

8.6. Third Party Beneficiary. This Agreement is entered into by the Parties signing it for their benefit, as well as, in the case of Health Plan, the benefit of Company, and in the case of Provider, the benefit of each Contracted Provider. Except as specifically provided in Section 3.4 hereof, no Covered Person or third party, other than Company, will be considered a third party beneficiary of this Agreement.

8.7. Amendment. Except as otherwise provided in this Agreement, this Agreement may be amended only by written agreement of duly authorized representatives of the Parties.

8.7.1. Health Plan may amend this Agreement by giving Provider written notice of the amendment to the extent such amendment is deemed necessary or appropriate by Health Plan to comply with any Regulatory Requirements. Any such amendment will be deemed accepted by Provider upon the giving of such notice.

8.7.2. Health Plan may amend this Agreement by giving Provider written notice (electronic or paper) of the proposed amendment. Unless Provider notifies Health Plan in writing of its objection to such amendment during the 30 day period following the giving of such notice by Health Plan, Provider shall be deemed to have accepted the amendment. If Provider objects to any proposed amendment to either the base agreement or any Attachment, Health Plan may exclude one or more of the Contracted Providers from being Participating Providers in the applicable Product (or any component program of, or Coverage Agreement in connection with, such Product).

8.8. Entire Agreement. All prior or concurrent agreements, promises, negotiations or representations either oral or written, between Health Plan and Provider relating to a subject matter of this Agreement, which are not expressly set forth in this Agreement, are of no force or effect.

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

8.10. Waiver. The waiver by either Party of the violation of any provision or obligation of this Agreement will not constitute the waiver of any subsequent violation of the same or other provision or obligation.

8.11. Notices. Except as otherwise provided in this Agreement, any notice required or permitted to be given hereunder is deemed to have been given when such written notice has been personally delivered or deposited in the United States mail, postage paid, or delivered in hard copy or electronically by a service that provides written receipt or acknowledgment of delivery, addressed as follows:

To Health Plan at:	To Provider at:
Attn: President	Attn: Test
Delaware First Health, Inc.	Test Agreement
750 Prides Crossing Suite 200	Test
Newark, DE 19713	Test, Test Test
	Kathryn.Nally@delawarefirsthealth.com

or to such other address as such Party may designate in writing. Notwithstanding the previous paragraph, Health Plan may provide notices by electronic mail, through its provider newsletter or on its provider website.

8.12. Force Majeure. Neither Party shall be liable or deemed to be in default for any delay or failure to perform any act under this Agreement resulting, directly or indirectly, from acts of God, civil or military authority,

acts of public enemy, war, accidents, fires, explosions, earthquake, flood, strikes or other work stoppages by either Party's employees, or any other similar cause beyond the reasonable control of such Party.

8.13. Proprietary Information. Each Party is prohibited from, and shall prohibit its Affiliates and Contracted Providers from, disclosing to a third party the substance of this Agreement, or any information of a confidential nature acquired from the other Party (or Affiliate or Contracted Provider thereof) during the course of this Agreement, except to agents of such Party as necessary for such Party's performance under this Agreement, or as required by a Payor Contract or applicable Regulatory Requirements. Provider acknowledges and agrees that all information relating to Company's programs, policies, protocols and procedures is proprietary information and Provider shall not disclose such information to any person or entity without Health Plan's express written consent.

8.14. Authority. The individuals whose signatures are set forth below represent and warrant that they are duly empowered to execute this Agreement. Provider represents and warrants that it has all legal authority to contract on behalf of and to bind all Contracted Providers to the terms of the Agreement with Health Plan. Provider and each Contracted Provider acknowledges that references herein to the rights and obligations of any "Company" or a "Payor" under this Agreement are references to the rights and obligations of each Company and each Payor individually and not of the Companies or Payors collectively. Notwithstanding anything herein to the contrary, all such rights and obligations are individual and specific to each such Company and each such Payor and the reference to Company or Payor herein in no way imposes any cross-guarantees or joint responsibility or liability by, between or among such individual Companies or Payors. A breach or default by an individual Company or Payor shall not constitute a breach or default by any other Company or Payor, including but not limited to Health Plan.

* * * * *

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

IN WITNESS WHEREOF, the Parties hereto have executed this Agreement, including all Product Attachments noted on Schedule B, effective as of the date set forth beneath their respective signatures.

HEALTH PLAN:

Delaware First Health, Inc.

Authorized Signature:

Print Name: William Wilson

Title: Plan President & CEO

Signature Date: {{$IntDate }}

ICM #: ICMProviderAgreement_348049

To be completed by Health Plan only:

Effective Date: {{$EffDate }}

PROVIDER:

Test Agreement
(Legibly Print Name of Provider)

Authorized Signature:

Print Name: {{*Name_es_:Signer1 }}

Title: {{*Ttl1_es_:Signer1:title }}

Signature Date: {{$ExtDate }}

Tax Identification Number: 33-3333333

National Provider Identifier: 3333333333

Medicare Number:

{{#EffDate=AgreementEffective_es_:signer2:calc(if(datePart("d", IntSignDate) <= 15, dateAdd("d", IntSignDate, (daysIn("m",IntSignDate) - datePart("d", IntSignDate) + 15)), dateAdd("d", IntSignDate, (daysIn("m",dateAdd("m",IntSignDate,1)) + (daysIn("m",IntSignDate) - datePart("d", IntSignDate) + 1))))):format(date, "mmm dd, yyyy")}}
{{#ExtDate=ExtSignDate_es_:signer1:date }}
{{#IntDate=IntSignDate_es_:signer2:date }}

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PARTICIPATING PROVIDER AGREEMENT

SCHEDULE A
CONTRACTED PROVIDER-SPECIFIC PROVISIONS

Provider and Contracted Providers shall comply with the applicable provisions of this Schedule A.

1. Hospitals. If Provider or a Contracted Provider is a hospital ("Hospital"), the following provisions apply.

1.1 24 Hour Coverage. Each Hospital shall be available to provide Covered Services to Covered Persons 24 hours per day, 7 days per week.

1.2 Emergency Care. Each Hospital shall provide Emergency Care (as hereafter defined) in accordance with Regulatory Requirements. The Contracted Provider shall notify Company's medical management department of any emergency room admissions by electronic file sent within 24 hours or by the next business day of such admission. "Emergency Care" (or derivative thereof) has, as to each particular Product, the meaning set forth in the applicable Coverage Agreement or Product Attachment. If there is no definition in such documents, "Emergency Care" means inpatient and/or outpatient Covered Services furnished by a qualified provider that are needed to evaluate or stabilize an Emergency Medical Condition. "Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.

1.3 Staff Privileges. Each Hospital shall assist in granting staff privileges or other appropriate access to Company's Participating Providers who are qualified medical or osteopathic physicians, provided they meet the reasonable standards of practice and credentialing standards established by the Hospital's medical staff and bylaws, rules, and regulations.

1.4 Discharge Planning. Each Hospital agrees to cooperate with Company's system for the coordinated discharge planning of Covered Persons, including the planning of any necessary continuing care.

1.5 Credentialing Criteria. Each Hospital shall: (a) currently, and for the duration of this Agreement, remain accredited by the Joint Commission or American Osteopathic Association, as applicable; and (b) ensure that all employees of Hospital perform their duties in accordance with all applicable local, State and federal licensing requirements and standards of professional ethics and practice.

1.6 National Committee for Quality Assurance ("NCQA") Accreditation of Health Plans Standards. Each Hospital agrees to: (i) cooperate with Quality Management and Improvement ("QI") activities; (ii) maintain the confidentiality of a Covered Persons information and records pursuant to the Agreement; and (iii) allow the Company to use Hospital's performance data.

2. Practitioners. If Provider or Contracted Provider is a physician or other health care practitioner (including physician extenders) ("Practitioner"), the following provisions apply.

2.1 Contracted Professional Qualifications. At all times during the term of this Agreement, Practitioner shall, as applicable, maintain medical staff membership and admitting privileges with at least one hospital that is a Participating Provider ("Participating Hospital") with respect to each Product in which the Practitioner participates. Upon Company's request, Practitioner shall furnish evidence of the foregoing to Company. If Practitioner does not have such admitting privileges, Provider or the Practitioner shall provide Company with a

written statement from another Participating Provider who has such admitting privileges, in good standing, certifying that such individual agrees to assume responsibility for providing inpatient Covered Services to Covered Persons who are patients of the applicable Practitioner.

2.2 Acceptance of New Patients. To the extent that Practitioner is accepting new patients, such Practitioner must also accept new patients who are Covered Persons with respect to the Products in which such Practitioner participates. Practitioner shall notify Company in writing 45 days prior to such Practitioner's decision to no longer accept Covered Persons with respect to a particular Product. In no event will an established patient of any Practitioner be considered a new patient.

2.3 Preferred Drug List/Drug Formulary. If applicable to the Covered Person's coverage, Practitioners shall use commercially reasonable efforts, when medically appropriate under the circumstances, to comply with formulary or preferred drug list when prescribing medications for Covered Persons.

2.4 National Committee for Quality Assurance ("NCQA") Accreditation of Health Plans Standards. Each Practitioner agrees to: (i) cooperate with Quality Management and Improvement ("QI") activities; (ii) maintain the confidentiality of a Covered Persons information and records pursuant to the Agreement; and (iii) allow the Company to use Practitioner's performance data.

3. Ancillary Providers. If Provider or Contracted Provider is an ancillary provider (including but not limited to a home health agency, durable medical equipment provider, sleep center, pharmacy, ambulatory surgery center, nursing facility, laboratory or urgent care center)("Ancillary Provider"), the following provisions apply.

3.1 Acceptance of New Patients. To the extent that Ancillary Provider is accepting new patients, such Ancillary Provider must also accept new patients who are Covered Persons with respect to the Products in which such Ancillary Provider participates. Ancillary Provider shall notify Company in writing 45 days prior to such Ancillary Provider's decision to no longer accept Covered Persons with respect to a particular Product. In no event will an established patient of any Ancillary Provider be considered a new patient.

3.2 National Committee for Quality Assurance ("NCQA") Accreditation of Health Plans Standards. Each ancillary provider agrees to: (i) cooperate with Quality Management and Improvement ("QI") activities; (ii) maintain the confidentiality of a Covered Persons information and records pursuant to the Agreement; and (iii) allow the Company to use ancillary provider's performance data.

4. FQHC. If Provider or a Contracted Provider is a federally qualified health center ("FQHC"), the following provision applies.

4.1 FQHC Insurance. To the extent FQHC's employees are deemed to be federal employees qualified for protection under the Federal Tort Claims Act ("FTCA") and Health Plan has been provided with documentation of such status issued by the U.S. Department of Health and Human Services (such status to be referred to as "FTCA Coverage"), Section 5.1 of this Agreement will not apply to those Contracted Providers with FTCA Coverage. FQHC shall provide evidence of such FTCA Coverage to Health Plan at any time upon request. FQHC shall promptly notify Health Plan if, any time during the term of this Agreement, any Contracted Provider is no longer eligible for, or if FQHC becomes aware of any fact or circumstance that would jeopardize, FTCA Coverage. Section 5.1 of this Agreement will apply to a Contracted Provider immediately upon such Contracted Provider's loss of FTCA Coverage for any reason.

5. Facility Providers. If Provider or a Contracted Provider is a facility (including but not limited to Clinic, FQHC, LTAC, Nursing Home, Rehab, Rural Health Clinic, Skilled Nursing) ("Facility Provider") the following provision applies.

5.1 National Committee for Quality Assurance ("NCQA") Accreditation of Health Plans Standards. Each facility agrees to: (i) cooperate with Quality Management and Improvement ("QI") activities; (ii) maintain the confidentiality of a Covered Persons information and records pursuant to the Agreement; and (iii) allow the Company to use facility's performance data.

6. Long Term Services and Supports ("LTSS") and Home and Community-Based Services ("HCBS") Providers. If Provider or a Contracted Provider is a provider of LTSS and/or HCBS services, the following provisions apply.

6.1 Definition. LTSS generally includes assistance with daily self-care activities (e.g., walking, toileting, bathing, and dressing) and activities that support an independent lifestyle (e.g., food preparation, transportation, and managing medications). The broad category of LTSS also includes care and service coordination for people who live in their own home, a residential setting, a nursing facility, or other institutional setting. Home and community-based services ("HCBS") are a subset of LTSS that functions outside of institutional care to maximize independence in the community.

6.2 HCBS Waiver Authorization. Provider shall not provide HCBS Covered Services to Covered Person without the required HCBS waiver authorization.

6.3 Conditions for Reimbursement. No payment shall be made to the Provider unless the Provider has strictly conformed to the policies and procedures of the HCBS Waiver Program, including but not limited to not providing HCBS Covered Services without prior authorization of Health Plan. For the purposes of this Exhibit, "HCBS Waiver Program" shall mean any special Medicaid program operated under a waiver approved by the Centers for Medicare and Medicaid Services which allows the provision of a special package of approved services to Covered Person.

6.4 Acknowledgement. Health Plan acknowledges that Provider is a provider of LTSS and is not necessarily a provider of medical or health care services. Nothing in this Agreement is intended to require Provider to provide medical or health care services that Provider does not routinely provide, but would not prohibit providers from offering these services, as appropriate.

6.5 Notification Requirements. Provider or the applicable Contracted Provider shall provide the following notifications to Health Plan, via written notice or via telephone contact at a number to be provided by Health Plan, within the following time frames:

6.5.1 Provider or the applicable Contracted Provider shall notify Health Plan of a Covered Person's visit to urgent care or the emergency department of any hospital, or of a Covered Person's hospitalization, within 24 hours of becoming aware of such visit or hospitalization.

6.5.2 Provider or the applicable Contracted Provider shall notify Health Plan of any change to the designated/assigned services being provided under a Covered Person's plan of care and/or service plan, within 24 hours of becoming aware of such change.

6.5.3 Provider or the applicable Contracted Provider shall notify Health Plan if a Covered Person misses an appointment with Provider, within 24 hours of becoming aware of such missed appointment.

6.5.4 Provider or the applicable Contracted Provider shall notify Health Plan of any change in a Covered Person's medical or behavioral health condition, within 24 hours of becoming aware of such change. (Examples of changes in condition are set forth in the Provider Manual.)

6.5.5 Provider or the applicable Contracted Provider shall notify Health Plan of any safety issue identified by Provider or Contracted Provider or its agent or subcontractor, within 24 hours of the identification of such safety issue. (Examples of safety issues are set forth in the Provider Manual.)

6.5.6 Provider or the applicable Contracted Provider shall notify Health Plan of any change in Provider's or Contracted Provider's key personnel, within 24 hours of such change.

6.6 Minimum Data Set. If Contracted Provider is a nursing facility, Provider or such Contracted Provider shall submit to Health Plan or its designee the Minimum Data Set as defined by CMS and required under federal law and Health Plan policy as it relates to all Covered Persons who are residents in Contracted Provider's facility. Such submission shall be via electronic mail, facsimile transmission, or other manner and format reasonably requested by Health Plan.

6.7 Quality Improvement Plan. Each Contracted Provider shall participate in Health Plan's LTSS quality improvement plan. Each Contracted Provider shall permit Health Plan to access such Contracted Providers' assessment and quality data upon reasonable advance notice, which may be given by electronic mail.

6.8 Electronic Visit Verification. If Contracted Provider provides in-home services, Contracted Provider shall comply with 21st Century Cures Act and Health Plan's electronic visit verification system requirements where applicable and accessible.

6.9 Criminal Background Checks. Provider shall conduct a criminal background check on each Contracted Provider prior to the commencement of services under this Agreement and as requested by Health Plan thereafter. Provider shall provide the results of such background checks to Health Plan and member, if self-directed, upon request. Provider agrees to immediately notify Health Plan of any criminal convictions of any Contracted or sub-contracted Provider. Provider shall pay any costs associated with such criminal background checks.

7. Person-Centered Planning, Care/Service Plan, and Services ("PCSP"). Provider shall comply with all state and federal regulatory requirements related to person-centered planning, care/service plans, and services including, but not limited to:

7.1 Covered Persons shall lead the person-centered planning process and can elect to include, and/or consult with, any of their LTSS providers in the care/service plan development process.

7.2 The care/service plan must be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation through the mechanism required by state and federal requirements. Non-medical service providers (such as meals or assistive technology) can signify their agreement through this contract or written agreement in lieu of directly in the plan, if permitted by the Covered Persons.

7.3 LTSS Provider shall be aware of, respect, and adhere to a Covered Person's preferences for the delivery of services and supports.

7.4 LTSS Provider shall ensure services and supports are culturally appropriate, provided in plain language (where applicable), and accessible to Covered Persons and the person(s) supporting them who have disabilities and/or are limited English proficient.

7.5 Health Plan agrees to complete the care/service plan in a timely manner (within at least 120 days of enrollment or annually, or less if state requirements differ) and provide a copy to LTSS Provider(s) responsible for implementation.

PARTICIPATING PROVIDER AGREEMENT

SCHEDULE B
PRODUCT PARTICIPATION

Provider will be designated as a "Participating Provider" in the Product Attachments listed below as of the date of successful completion of credentialing in accordance with this Agreement.

List of Product Attachments:
Attachment A: Medicaid
Attachment B: [Reserved]
Attachment C: [Reserved]
Attachment D: [Reserved]
Attachment E: [Reserved]
Attachment F: [Reserved]

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PARTICIPATING PROVIDER AGREEMENT

SCHEDULE C
INFORMATION FOR CONTRACTED PROVIDERS

Provider shall provide Health Plan with the information set forth below with respect to: (i) Provider; (ii) each Contracted Provider; and (iii) if applicable, each Contracted Provider's locations and/or professionals. To the extent Provider provides the name of any Contracted Provider to Health Plan hereunder, such entity and/or individual will be considered a Contracted Provider under this Agreement regardless of whether the complete list of information set forth below relating to such Contracted Provider is provided by Provider.

1. Name
2. Address
3. E-mail address
4. Telephone and facsimile numbers
5. Professional license numbers
6. Medicare/Medicaid ID numbers
7. Federal tax ID numbers
8. Completed W-9 form
9. National Provider Identifier (NPI) numbers
10. Provider Taxonomy Codes
11. Area of medical specialty
12. Age restrictions (if any)
13. Area hospitals with admitting privileges (where applicable)
14. Whether Providers are employed or subcontracted with Contracted Provider using the designation "E" for employed or "C" for subcontracted.
15. For a subcontracted Provider, whether its Providers are employed or contracted with the subcontracted Provider using the designation "E" for employed or "C" for contracted.
16. Office contact person
17. Office hours
18. Billing office
19. Billing office address
20. Billing office telephone and facsimile numbers
21. Billing office e-mail address
22. Billing office contact person
23. Ownership Disclosure Form, as required to comply with Regulatory Requirements and Governmental Contract

NOTE: For a complete listing of the information and additional documentation required, please refer to the enrollment application.

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Attachment A: Medicaid

PRODUCT ATTACHMENT
Delaware

THIS PRODUCT ATTACHMENT (this "***Attachment***") is made and entered between Delaware First Health, Inc. ("***Health Plan***") and Test Agreement ("***Provider***").

WHEREAS, Health Plan and Provider entered into that certain participating provider agreement, as the same may have been amended and supplemented from time to time (the "***Agreement***"), pursuant to which Provider and its Contracted Providers participate in certain Products offered by or available from or through a Company;

WHEREAS, pursuant to the provisions of the Agreement, Contracted Providers will be designated and participate as Participating Providers (defined herein) in the Product described in this Attachment; and

WHEREAS, Health Plan has contracted with the Delaware's Department of Health and Social Services ("***DHSS")***, Division of Medicaid and Medical Assistance ("***DMMA***") (together "***DHSS/DMMA***" or "***the State***"), to be a Medicaid Managed Care Organization ("***MCO***") to provide Covered Services to Covered Persons in the Diamond State Health Plan ("***DSHP***") and Diamond State Health Plan Plus ("***DSHP Plus***") Medicaid programs (together "***Medicaid Product***") (sometimes "***Programs***") and such other programs as may be awarded to Health Plan by DHSS/DMMA.

WHEREAS, the Agreement is modified or supplemented as hereafter provided.

NOW THEREFORE, in consideration of the recitals, the mutual promises herein stated, the parties hereby agree to the provisions set forth below.

1. Defined Terms. For purposes of this Medicaid Product Attachment, all capitalized terms not specifically defined in this Attachment will have the meanings given to such terms in the Agreement. Citations to the State Contract or other Regulatory Requirements in this Medicaid Product Attachment are provided herein for convenience only and shall not affect the meaning or interpretation of the terms of this Attachment. Such citations may become outdated as these requirements are amended from time to time.

2. Product Participation.

2.1. DSHP and DSHP Plus. This Attachment addresses the participation of Provider and the applicable Contracted Providers in the Medicaid Product. The Medicaid Product includes those programs and health benefit arrangements offered by Health Plan or other Company pursuant to a contract (the "***State Contract***") with the DHSS/DMMA, or any successor thereto, to provide specified services and goods to covered beneficiaries under the Programs (or additional, ancillary or successor State Medicaid programs thereto), and to meet certain performance standards while doing so. The Medicaid Product does not apply to any Coverage Agreements that are specifically covered by another Product Attachment to the Agreement. This Attachment applies only to the provision of health care services, supplies or accommodations (including Covered Services) to Covered Persons enrolled in the Medicaid Product.

Where Company is not the Payor, the rights and responsibilities assigned under this Attachment to Company, Payor, or "Company or Payor" shall be understood to apply to either Company or Payor as applicable under the circumstances and as determined by the terms of the Payor Contract, Regulatory Requirements and/or Company policies and procedures. The phrase "Company or Payor" is not intended to nor shall result in the expansion of any rights on the part of Provider or Contracted Providers or any liabilities on the part of Company or Payor. Nothing in this Attachment shall be construed as conferring any financial or legal liabilities of Payor under any Regulatory Requirements or the Payor Contract to Company or Health Plan. Nothing in this Attachment shall be construed as

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altering the terms of the Payor Contract, or in a manner that is inconsistent with Regulatory Requirements. The rights and responsibilities that arise under a Payor Contract (including a Governmental Contract) and that are assigned under this Attachment to Health Plan are understood to be assigned to Company (and references to "Health Plan" will be understood to be references to Company) where Company is a party to the Payor Contract.

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

2.3. Attachment. This Attachment constitutes the Product Attachment for the Medicaid Product.

2.4. Construction. Except as expressly provided herein, the terms and conditions of the Agreement will remain unchanged and in full force and effect. In the event of a conflict between the provisions of the Agreement and the provisions of this Attachment, this Attachment will govern with respect to health care services, supplies or accommodations (including Covered Services) rendered to Covered Persons enrolled in the Medicaid Product. To the extent any provision of this Attachment, or any provision of the Agreement as it relates to this Attachment, (including any exhibit, attachment, or other document referenced herein) is inconsistent with or contrary to any provision of the State Contract, the relevant provision of the State Contract shall have priority and control over the matter. To the extent Provider or any Contracted Provider is unclear about its, his or her respective duties and obligations, Provider or the applicable Contracted Provider shall request clarification from the Company.

3. Term. This Attachment will be coterminous with the Agreement unless a party or a Contracted Provider terminates the participation of the Contracted Provider in the Medicaid Product in accordance with the applicable provisions of the Agreement or this Attachment. Notwithstanding the above, Health Plan may immediately terminate this Attachment upon notice to Provider in the event that the State Contract is terminated or the Program (or any aspect thereof) is no longer authorized by law (i.e., has been vacated by a court of law, CMS has withdrawn federal authority for the program, or the program is the subject of a legislative repeal).

4. Governmental Contract/Regulatory Requirements. Schedule A to this Attachment, which is incorporated herein by this reference, sets forth the special provisions that are applicable to the Medicaid Product under the State Contract and the provisions that are required by the State Contract to be included in the Agreement with respect to the Medicaid Product. Provider shall expressly impose these terms and obligations, in writing, on each of its Contracted Providers, as such term is defined in the Agreement. Health Plan is and shall be a third-party beneficiary of any agreement between Provider and its Contracted Providers with the right to directly enforce these terms and condition upon Contracted Providers. Applicable State agencies have the right to modify, supplement, amend and add to the terms, conditions and obligations set forth in Schedule A, and Contracted Providers shall be bound by such changes. Citations to the State Contract are being provided herein for convenience only and shall not affect the meaning or interpretation of the terms of this schedule. Such citations may become outdated as the State Contract is amended from time to time.

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SCHEDULE A
GOVERNMENTAL CONTRACT REQUIREMENTS

This Schedule A sets forth the special provisions that are specific to the Delaware Medicaid Product under the applicable State Contract.

1. Definitions. The following terms shall have the meaning stated, unless the context clearly indicates otherwise. In general, unless otherwise indicated, to improve the readability of Schedule A, the initial letter of each word in a defined term is capitalized. Any capitalized terms used in this Schedule A not defined below shall have the meaning assigned in the State Contract.

1.1 **Abuse** – For purposes of program integrity, in accordance with 42 CFR 455.2, provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid and CHIP program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. Abuse also includes client/member practices that result in unnecessary cost to the Medicaid and CHIP program (see 42 CFR 455.2).

1.2 **Adult** – Except as otherwise specified in the State Contract, an individual age 18 years of age or older.

1.3 **Adverse Benefit Determination** - In accordance with 42 CFR 438.400(b), the denial or limited authorization of a requested service, including determinations based on the type or level of service; requirements for Medical Necessity (see Section 3.4.5, Medical Necessity Determination), appropriateness, setting, or effectiveness of a Covered Service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner, as defined by the State; the failure of the Health Plan to act within timeframes provided in the State Contract regarding the standard resolution of Grievances and Appeals; and the denial of a member's request to dispute a financial liability, including cost sharing, copayments, and other member financial liabilities. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of "clean claim" is not an adverse benefit determination.

1.4 **Appeal** – In accordance with 42 CFR 438.400(b), a review by the Health Plan of an Adverse Benefit Determination.

1.5 **Assisted Living Facility** – A licensed entity that provides assisted living services in a homelike and integrated community setting. Assisted living services are defined in State law as a special combination of housing, supportive services, supervision, personalized assistance and health care designed to respond to the individual needs of those who need help with Activities of Daily Living (ADLs) and/or Instrumental Activities of Daily Living (IADLs).

1.6 **Behavioral Health** – The umbrella term for mental health conditions (including psychiatric illnesses and emotional disorders) and substance use disorders (involving addictive and chemical dependency disorders). The term also refers to preventing and treating co-occurring mental health conditions and substance use disorders (SUDs).

1.7 **Business Days** – Monday through Friday, except for State of Delaware holidays.

1.8 **Calendar Days** – All seven days of the week, including State of Delaware holidays.

1.9 **Caregiver** – A person who is a family member or is unrelated to the member and is routinely involved in providing unpaid support and assistance to the member.

1.10 **Children's Health Insurance Program (CHIP)** – The joint federal/State program of medical assistance for uninsured children established by Title XXI of the Social Security Act, which in Delaware is administered by DMMA. See Delaware Healthy Children Program (DHCP).

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1.11 **Claim** – In accordance with 42 CFR 447.45, (i) a bill for services submitted to the Health Plan manually or electronically, (ii) a line item of service on a bill, or (iii) all services for one member within a bill, in a format prescribed by the State.

1.12 **Clean Claim** – In accordance with 42 CFR 447.45, a Claim that can be processed without obtaining additional information from the provider of the service or from a third-party. It includes a Claim with errors originating in a State's Claims system. It does not include a Claim from a provider who is under investigation for Fraud, Waste or Abuse, or a Claim under review for Medical Necessity.

1.13 **Days** – Calendar days unless otherwise specified.

1.14 **Diamond State Health Plan (DSHP) –** The program that provides services through a managed care delivery system to Medicaid clients who are not eligible for Medicare or DSHP Plus LTSS and children in DHCP. DSHP members are eligible to receive the DSHP benefit package described in Section 3.4.2 of the State Contract, DSHP Benefit Package.

1.15 **Diamond State Health Plan Plus (DSHP Plus)** – The program that provides services through a managed care delivery system to Medicaid clients with Medicare, clients participating in the Medicaid for Workers with Disabilities (Medicaid Buy-in) program, and Medicaid clients who are eligible for DSHP Plus LTSS. DSHP Plus members are eligible to receive the DSHP benefit package in Section 3.4.2 of the State Contract. DSHP Plus LTSS members are eligible to receive both the DSHP benefit package described in Section 3.4.2 of the State Contract and the DSHP Plus LTSS benefit package described in Section 3.4.3 of the State Contract, DSHP Plus LTSS Benefit Package.

1.16 **Diamond State Health Plan Plus Long Term Services and Supports (DSHP Plus LTSS)** – The program that provides services, including long term services and supports, through a managed care delivery system to DSHP Plus members who meet nursing facility Level of Care or are "at risk" for nursing facility Level of Care, DSHP Plus members who meet the hospital Level of Care criteria and have HIV/AIDS, and DSHP Plus members under age 21 who meet nursing facility Level of Care and reside in a nursing facility. DSHP Plus LTSS members are eligible to receive both the DSHP benefit package described in Section 3.4.2 of the State Contract and the DSHP Plus LTSS benefit package described in Section 3.4.3 of the State Contract.

1.17 **Downstream Entity** - Any entity that enters into a written arrangement with a Subcontractor or below the level of a Subcontractor to provide administrative services pursuant to the State Contract. This includes all entities with written arrangements that continue down to the level of the ultimate provider of the administrative service.

1.18 **Early and Periodic Screening, Diagnostic and Treatment (EPSDT)** – The federally required program for clients under the age of 21, as defined in Section 1905(r) of the Social Security Act and 42 CFR Part 441, Subpart B. It includes periodic comprehensive screening and diagnostic services to determine health care needs as well as the provision of all Medically Necessary services listed in Section 1905(a) of the Social Security Act even if the service is not available under the State's Medicaid plan.

1.19 **Emergency Medical Condition** - In accordance with 42 CFR 438.114, a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairments to bodily functions, or serious dysfunction of any bodily organ or part.

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1.20 **Emergency Services** – In accordance with 42 CFR 438.114, covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish these services under Delaware Medicaid and that are needed to evaluate or stabilize an Emergency Medical Condition.

1.21 **Enroll/Enrollment** – The process by which a client becomes a member of an MCO.

1.22 **Encounter Data** – In accordance with the definition of enrollee encounter data in 42 CFR 438.2, the information relating to the receipt of any item(s) or service(s) by a member under the State Contract that is subject to the requirements of 42 CFR 438.242 and 438.818.

1.23 **Federally Qualified Health Center (FQHC)** – An entity that is receiving a grant under Section 330 of the Public Health Service Act.

1.24 **Fee-for-Service (FFS)** – A method of making payment for health services based on a fee schedule that specifies payment for defined services.

1.25 **Fraud** – In accordance with 42 CFR 455.2, an intentional deception or misrepresentation by a person or an entity, with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes Fraud under applicable federal or State law.

1.26 **Grievance** – In accordance with 42 CFR 438.400(b), an expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Grievances may include, but are not limited to, the quality of care or services provided and aspects of interpersonal relationships, such as rudeness of a provider or employee or failure to respect the member's rights regardless of whether remedial action is requested. Grievance includes a member's right to dispute an extension of time proposed by the Health Plan to make an authorization decision.

1.27 **Grievance and Appeal System** – In accordance with 42 CFR 438.400(b), the processes the Health Plan implements to handle Grievances and Appeals of an Adverse Benefit Determination, as well as the processes to collect and track information about Grievances and Appeals.

1.28 **Health Care Services** – In accordance with 42 CFR 438.320, all Medicaid services provided by the Health Plan in any setting, including, but not limited to, physical health services, Behavioral Health services and LTSS.

1.29 **Health-Related Social Need (HRSN)** – An individual member social need that adversely impacts the member's health or health care utilization. Examples include: housing instability and quality (e.g., homelessness, poor housing quality, inability to pay mortgage/rent); utility needs (e.g., difficulty paying utility bills); food insecurity; interpersonal violence (e.g., intimate partner violence, elder abuse, child maltreatment); transportation needs beyond medical transportation; family and social supports (e.g., prenatal support services, child care, social isolation, respite services, caregiver support); education (e.g., English as a Second Language (ESL), General Education Development (GED), or other education programs); and employment and income.

1.30 **Home and Community Based Services (HCBS)** – Services that are provided to DSHP Plus LTSS members residing in homelike and integrated community settings as an alternative to long term care institutional placement.

1.31 **Law** – Statutes, codes, rules, regulations, and/or court rulings.

1.32 **Level of Care (LOC)** – The type of long term services and supports required by a member based on the member's medical and functional needs as determined by the State's Pre-Admission Evaluation (PAE), which includes nursing facility Level of Care, Level of Care for individuals at risk of institutionalization and acute hospital Level of Care.

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1.33 **Limited English Proficiency (LEP)** – In accordance with 42 CFR 438.10, potential member or member who does not speak English as their primary language and who has a limited ability to read, write, speak, or understand English, and may be eligible to receive language assistance for a particular type of service, benefit, or encounter.

1.34 **List of Excluded Individuals and Entities (LEIE)** – A database of individuals and entities excluded from federally-funded health care programs maintained by the Department of Health and Human Services Office of the Inspector General.

1.35 **Long Term Services and Supports (LTSS)** – In accordance with 42 CFR 438.2, the services and supports described in Section 3.4.3 of the State Contract provided to DSHP Plus LTSS members who have functional limitations and/or chronic illness that have the primary purpose of supporting the ability of the member to live or work in the setting of their choice, which may include the individual's home, a worksite, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting.

1.36 **Managed Care Organization (MCO)** – Any entity that meets the requirements of 42 CFR 438.2 and is under contract with the State of Delaware to provide services to DSHP and DSHP Plus members.

1.37 **Marketing** – In accordance with 42 CFR 438.104, any communication from the Health Plan to a client who is not Enrolled with Health Plan, that can reasonably be interpreted as intended to influence the client to Enroll with Health Plan, or whether or not Enroll in, or to Transfer from another MCO. Marketing does not include communication to a client from the issuer of a qualified health plan, as defined in 45 CFR 155.20 about the qualified health plan.

1.38 **Marketing Materials** – In accordance with 42 CFR 438.104, materials that are produced in any medium by or on behalf of the Health Plan that can reasonably be interpreted as intended Marketing to potential members.

1.39 **Medicaid** – The joint federal/State program of medical assistance established by Title XIX of the Social Security Act, 42 USC 1396 et seq., which in Delaware is administered by DMMA.

1.40 **Medicaid State Plan (State Plan)** – A comprehensive written plan submitted by the State and approved by CMS that describes the nature and scope of the State's Medicaid program, including, but not limited to, eligibility standards, provider requirements, payment methods, and Health Care Services.

1.41 **Medically Necessary or Medical Necessity** – The essential need for health care or services which, when delivered by or through authorized and qualified providers, will (a) be directly related to the prevention, diagnosis and treatment of a Covered Person's disease, condition, and/or disorder that results in health impairments and/or disability (the physical or mental functional deficits that characterize the Covered Person's condition), and be provided to the Covered Person only; (b) be appropriate and effective to the comprehensive profile (e.g., needs, aptitudes, abilities, and environment) of the Covered Person and the Covered Person's family; (c) be primarily directed to the diagnosed medical condition of the effects of the condition of the Covered Person, in all settings for normal activities of daily living (ADLs), but will not be solely for the convenience of the Covered Person, the Covered Person's family, or the Covered Person's provider; (d) be timely, considering the nature and current state of the Covered Person's diagnosed condition and its effects, and will be expected to achieve the intended outcomes in a reasonable time; (e) be the least costly, appropriate, available health service alternative, and will represent an effective and appropriate use of funds; (f) be the most appropriate care or service that can be safely and effectively provided to the Covered Person, and will not duplicate other services provided to the Covered Person; (g) be sufficient in amount, scope and duration to reasonably achieve its purpose; (h) be recognized as either the treatment of choice (e.g., prevailing community or Statewide standard) or common medical practice by the practitioner's peer group, or the functional equivalent of other care and services that are commonly provided; and (i) be rendered in response to a life-threatening condition or pain, or to treat an injury, illness, or other diagnosed condition, or to treat effects of a diagnosed condition that has resulted in or could result in a physical or mental limitation, including loss of physical

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or mental functionality or developmental delay; in addition, for Covered Persons enrolled in DSHP Plus LTSS, (j) provide the opportunity for such Covered Persons to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice.

1.42 **Medicare** – The medical assistance program authorized by Title XVIII of the Social Security Act.

1.43 **Member** (also **Covered Person**) – In accordance with the definition of enrollee in 42 CFR 438.2, a Medicaid or DHCP client who Enrolls with Health Plan under the provisions of the State Contract (see Section 3.2 of the State Contract). Includes both DSHP and DSHP Plus members and their representatives.

1.44 **Nursing Facility (NF)** – A facility that meets the requirements of Sections 1819 or 1919 of the Social Security Act and 42 CFR Part 483 and is licensed and certified as a Medicaid nursing facility.

1.45 **Overpayment** – In accordance with 42 CFR 438.2, any payment made to a participating provider by the Health Plan to which the participating provider is not entitled to under Title XIX of the Social Security Act or any payment to a Health Plan by the State to which the Health Plan is not entitled.

1.46 **Participating Provider** – In accordance with the definition of network provider in 42 CFR 438.2, any provider, group of providers, or entity that is employed by or has signed a provider participation agreement with the Health Plan or Subcontractor/Downstream Entity, and receives Medicaid funding directly or indirectly to order, refer, or provide Health Care Services. A Participating Provider is not a Subcontractor/Downstream Entity by virtue of the participation agreement. Participating Provider does not include Self-Directed HCBS Employees; nor does Participating Provider include the provider of support for Self-Directed HCBS.

1.47 **Patient Liability** – The amount of a member's income, as determined by the State, to be collected each month to help pay for the member's LTSS.

1.48 **Peer Review** – An evaluation of the professional practices of a provider by the provider's peers. The evaluation assesses the necessity, appropriateness and quality of care furnished by the provider in comparison to care customarily furnished by the provider's peers and consistency with recognized health care standards.

1.49 **Potential Member** – In accordance with the definition of potential enrollee in 42 CFR 438.2, a client who is subject to mandatory Enrollment in DSHP or DSHP Plus, but who is not yet a member of a specific MCO.

1.50 **Pre-Admission Screening and Resident Review (PASRR)** – A federal requirement (see Section 1919(e)(7) of the Social Security Act and 42 CFR Part 483, Subpart C) to help ensure that individuals are not inappropriately placed in nursing facilities for long term services and supports. PASRR requires that (i) all applicants to a Medicaid certified nursing facility be evaluated for mental illness and/or intellectual disability; (ii) be offered the most appropriate setting for their needs (in the community, a nursing facility, or acute care settings); and (iii) receive the services they need in those settings.

1.51 **Primary Care** – In accordance with 42 CFR 438.2, all Health Care Services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist (OB/GYN), pediatrician, or other licensed practitioner as authorized by the State, to the extent the furnishing of those services is legally authorized in the State in which the practitioner furnishes them.

1.52 **Primary Care Provider (PCP)** – A provider that has the responsibility for coordinating and providing Primary Care to members, initiating referrals for specialist care and maintaining the continuity of the member's care, as further described in Section 3.9.10 of the State Contract, Primary Care Provider.

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1.53 **Promoting Optimal Mental Health for Individuals through Supports and Empowerment (PROMISE)** – A program administered by the Division of Substance Abuse and Mental Health (DSAMH) that provides HCBS in the most integrated setting to Adults meeting targeted Behavioral Health diagnostic and functional limitations.

1.54 **Protected Health Information (PHI)** – Per 45 CFR 160 and 45 CFR 164, individually identifiable health information that is transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium.

1.55 **Provider Preventable Conditions (PPCs)** – The minimum set of conditions, including infections and events that have been identified for non-payment according to Delaware's Medicaid State Plan.

1.56 **Quality Management/Quality Improvement (QM/QI)** – The process of developing and implementing strategies to ensure the delivery of available, accessible, timely, and Medically Necessary Health Care Services that meet optimal clinical standards. This includes the identification of key measures of performance, discovery and data collection processes, identification and remediation of issues, and systems improvement activities.

1.57 **Readily Accessible** – In accordance with 42 CFR 438.10, electronic information and services that comply with modern accessibility standards such as Section 508 guidelines, Section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines (WCAG) 2.0 AA and successor versions.

1.58 **Related Entity** – Any entity related to the Health Plan by common ownership or control. A Related Entity includes but is not limited to agents, managing employees, individuals with an ownership or controlling interest in the Health Plan and their immediate families, wholly-owned subsidiaries or suppliers, parent companies, sister companies, holding companies, and other entities controlled or managed by any such entities or individuals.

1.59 **Representative** – A person who has the legal right to make decisions on behalf of a member, including parents of un-emancipated minors, guardians, and agents designated pursuant to a power of attorney for health care. For DSHP Plus LTSS members, this includes a person empowered by law, judicial order or power of attorney, or otherwise authorized by the DSHP Plus LTSS member to make decisions on behalf of the member. For members enrolled in the Division of Developmental Disabilities Services (DDDS) Lifespan Waiver, this term includes persons empowered by law, judicial order or power of attorney, through a supported decision-making agreement, or otherwise authorized by the member to make decisions on behalf of the member.

1.60 **Routine Care** – The treatment of a condition that would have no adverse effects if not treated within 48 hours or could be treated in a less acute setting (e.g., physician's office) or by the patient.

1.61 **Specialized Services for Nursing Facility Residents (Specialized Services)** - Any service or support recommended by an individualized Level II determination that a particular nursing facility resident requires due to mental illness or to intellectual disability or related condition that supplements the scope of services that the facility must provide under reimbursement as nursing facility services and is authorized by the State. Includes both Specialized Services for Nursing Facility Residents with Mental Illness and Specialized Services for Nursing Facility Residents with Developmental Disabilities.

1.62 **Specialized Services for Nursing Facility Residents with Mental Illness** - Any service or support recommended by an individualized Level II determination that a particular nursing facility resident requires due to mental illness that supplements the scope of services that the facility must provide under reimbursement as nursing facility services and is authorized by DSAMH.

1.63 **Specialized Services for Nursing Facility Residents with Developmental Disabilities** - Any service or support recommended by an individualized Level II determination that a particular nursing facility resident requires due to intellectual disability or related condition that supplements the scope of services that the facility must provide under reimbursement as nursing facility services and is authorized by DDDS.

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1.64 **State** – The State of Delaware, including, but not limited to, any entity or authorized representative of the State.

1.65 **State Fair Hearing** – In accordance with 42 CFR 438.400(b), the process set forth in 42 CFR Part 431, Subpart E and Title 16 DE Admin Code 5000.

1.66 **Subcontract** – A written or verbal agreement entered into by the Health Plan with any organization or person, including a Related Entity, to perform any administrative function or service for the Health Plan specifically related to securing or fulfilling the Health Plan's administrative obligations to the State under the terms of the State Contract (e.g., credentialing, Claims processing) when the intent of such an agreement is to delegate the responsibility for any administrative functions required by the State Contract. This shall include any and all agreements with any and all Subcontractors related to securing or fulfilling the Health Plan's administrative obligations to the State under the terms of the State Contract. If the Subcontract includes the provision or securing the provision of Health Care Services to members, the Health Plan shall ensure that all requirements described in Section 3.10 of the State Contract, Provider Participation Agreements, are included in the Subcontract and/or a separate provider participation agreement is executed by the appropriate parties. A provider participation agreement is not considered a Subcontract.

1.67 **Subcontractor** – In accordance with 42 CFR 438.2, any individual or entity, including a Related Entity, that has entered into a Subcontract to provide any function or service for the Health Plan specifically related to securing or fulfilling the Health Plan's obligations to the State under the terms of the State Contract. Subcontractor does not include a Participating Provider unless the Participating Provider is responsible for services other than providing Health Care Services pursuant to a provider participation agreement.

1.68 **Third-party** – For purposes of the definition of Third-party Liability (TPL), in accordance with 42 CFR 433.136, any individual, entity or program that is or may be liable to pay all or part of the expenditures for Health Care Services.

1.69 **Third-party Liability (TPL)** – Any amount due for all or part of the cost of Health Care Services from a Third-party.

1.70 **Transfer** – A member's change from Enrollment in one MCO to Enrollment in a different MCO.

1.71 **Trauma-Informed Care** – The delivery of care in a manner that understands and considers the pervasive nature of trauma and promotes environments of healing and recovery rather than practices and services that may inadvertently re-traumatize.

1.72 **Urgent Care** – Treatment of a condition that is potentially harmful to a patient's health and for which it is Medically Necessary for the patient to receive treatment within 48 hours to prevent deterioration.

1.73 **Utilization Management (UM)** – A system for reviewing the appropriate and efficient allocation of Health Care Services that are provided, or proposed to be provided, to a member.

1.74 **Waste** – Health care spending that can be eliminated without reducing quality of care.

2. Requirements Applicable to Providers:

2.1 Compliance with Law and State Contract. Provider and its Contracted Providers agree to abide by all State and federal law and program requirements applicable to the Provider and its Contracted Providers. The Agreement incorporates by reference all applicable federal and State laws, and those revisions of applicable federal and State laws are automatically incorporated into the Agreement as they become effective. **(§3.10.2.1.42)** If any requirement in the Agreement is determined by the State to conflict with the State Contract, such requirement shall be null and

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void and all other provisions shall remain in full force and effect. **(§3.10.2.1.59)** Moreover, no other terms or conditions agreed to by the Health Plan and Provider shall negate or supersede the requirements listed in Section 3.10.1 or Section 3.10.2 of the State Contract. **(§3.10.2.2)**

2.2 Amendments. Provider understands and agrees: (i) any changes to the Agreement that may materially affect members must be approved by the State prior to execution **(§3.10.1.2);** (ii) the Agreement shall be revised, modified and amended, as directed by the State. **(§3.10.1.4)**

2.3 Training. Provider and its Contracted Providers shall participate in such training provided by Health Plan as Health Plan deems reasonably necessary to ensure satisfactory performance of the State Contract. **(§3.10.1.5)**

2.4 No Exclusivity. Notwithstanding anything herein to the contrary, in no event is Provider prohibited from providing services for any other MCO or entering into a contractual relationship with another MCO. **(§§3.10.1.6** and **3.10.1.7)**

2.5 No Restriction. Notwithstanding anything contained in the Agreement to the contrary and in accordance with 42 CFR 438.102, Provider and its Contracted Providers understand that, if acting within the lawful scope of practice, Provider and Contracted Providers are not prohibited or restricted from advising or advocating for a Covered Person who is a patient in the following areas: (i) the Covered Person's health status, medical care or treatment for the Covered Person's condition of disease including any alternative treatment that may be self-administered, regardless of whether such care or treatment are Covered Service; (ii) any information the Covered Person needs in order to decide among relevant treatment options; (iii) the risks, benefits and consequences of treatment or non-treatment; and (iv) the Covered Person's right to participate in decisions regarding their health care, including the right to refuse treatment, and to express preferences about future treatment decisions. **(§§3.9.6** and **3.10.1.9)**

2.6 No Arbitrary Denial or Reduction. In accordance with 42 CFR 438.210, Provider and its Contracted Providers may not arbitrarily deny or reduce the amount, duration, or scope of required services solely because of the Covered Person's diagnosis, type of illness, or condition. **(§§3.4.5.2** and **3.10.2.1.3)**

2.7 Medical Necessity. Provider and its Contracted Providers shall render Covered Services in accordance with Medical Necessity as defined in the State Contract. **(§§ 3.4.5.1** and **3.10.2.1.4)**

2.8 Entire Agreement. The Agreement, and its attachments, contain all the terms and conditions agreed upon by Health Plan and Provider. **(§3.10.2.1.7)**

2.9 Accessibility and Appointments. Provider and its Contracted Providers shall comply with applicable access requirements, including, but not limited to, the following: **(§§3.9.15.3.8** and **3.10.2.1.8)**

General Standards:

a. Emergency Services are available 24 hours a day, seven days a week.

b. PCP appointments that meet the definition of an "emergency condition" are available the same day. Examples of emergency conditions are: high-grade fever, persistent vomiting or diarrhea or symptoms which are of sudden or severe onset but which do not require emergency room services.

c. PCP appointments for Urgent Care are available within two Calendar Days. Examples of Urgent Care include: persistent rash, non-specific pain, or severe sore throat or cough.

d. Routine Care appointments (e.g., well-child exams, routine physical exams) are available within three weeks of Covered Person request.

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Specialty Services:

a. Emergency care on an immediate basis, at the nearest facility available, regardless of whether the facility is a participating provider.

b. Urgent Care appointments within 48 hours of Covered Person request.

c. Routine appointments within three weeks of Covered Person request.

Maternity Care:

a. First trimester within three weeks of Covered Person request.

b. Second trimester within seven Calendar Days of Covered Person request.

c. Third trimester within three Calendar Days of Covered Person request.

d. High-risk pregnancies within three Calendar Days of identification of high risk by the Health Plan or maternity care provider, or immediately if an emergency exists.

Behavioral Health:

a. Emergency Services within 24 hours of request.

b. Immediate treatment for Covered Persons experiencing a Behavioral Health crisis, including a mobile team response based on the acuity of the Covered Person and not to exceed one hour from the request.

c. Follow-up outpatient services within two Business Days for:

i. Covered Persons being discharged from an inpatient or residential setting to a community placement; and

ii. Covered Persons seen in an emergency room, or by a Behavioral Health crisis provider for a Behavioral Health condition.

e. Routine outpatient services within seven Calendar Days of request with a non-prescribing clinician for an initial assessment.

e. Non-emergency outpatient services within three weeks of request for prescribing clinician services.

Office Waiting Times:

Covered Persons with appointments shall not wait longer than one hour. Office visits can be delayed when Contracted Providers “work in” urgent cases, when a serious problem is found, or when a patient had an unknown need that requires more services or education than was described at the time the appointment was made. If Contracted Provider is delayed, Covered Persons must be notified as soon as possible so they understand the delay. If the delay will result in a more than a 90 minute wait, then the Covered Person must be offered a new appointment.

Contracted Provider shall offer hours of operation that are no less than the hours of operation offered to commercial patients. **(§3.10.2.1.52)**

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Contracted Provider shall maintain a master history of appointments for a minimum of one year from the date of service to allow for monitoring and investigation of Grievances related to scheduling. **(§3.9.15.3.5)** If Contracted Provider fails to comply with appointment standards, then, upon Health Plan's request, Contracted Provider shall implement a corrective action plan to remedy such failure. **(§3.9.15.3.7)**

2.10 Laboratory Services. If Contracted Provider performs laboratory services, Contracted Provider must meet all applicable requirements of the Clinical Laboratory Improvement Amendments (CLIA) of 1988, including either a CLIA certification or waiver of certification with a CLIA identification number. **(§3.10.2.1.9)**

2.11 Record Keeping, Inspections and Audits.

a. Contracted Provider shall maintain and share, as appropriate, complete and accurate medical records in accordance with the Health Plan's policies and in accordance with professional standards. Provider shall maintain complete and accurate medical records for each member. Complete medical records shall include, but are not limited to, medical charts, hospital records, physician specialists, consultant and other providers' findings, and other documentation sufficient to disclose the quantity, quality, appropriateness, and timeliness of services provided. The content of medical records shall be consistent with the utilization control requirements in 42 CFR Part 456. Medical records must also be: (i) maintained in a detailed and comprehensive manner that conforms to good professional health care practice, permits effective professional review and audit processes, and facilitates an adequate system for follow-up treatment. Medical records must be legible, signed, and dated; (ii) documented accurately and in a timely manner, are Readily Accessible, and permit prompt and systemic retrieval of information; (iii) maintained in a confidential manner consistent with applicable law; (iv) promptly transferred to other providers of the Covered Person, without charge, for the medical management of the Covered Person; (v) forwarded to the new PCP of Covered Person within 10 Business Days of request; (vi) available without charge to duly authorized representatives of the State and CMS to evaluate, through inspections or other means, the quality, appropriateness and timeliness of services provided; (vii) available to Health Plan without charge upon request; (viii) amended or corrected upon request of a Covered Person consistent with 45 CFR Part 164; and (ix) maintained for a minimum of 10 years from the expiration of the State Contract. **(§§ 3.13.13** and **3.10.2.1.10)**

b. Contracted Provider shall maintain an adequate record system, including, but not limited to, medical and financial records, and all records shall be retained for 10 years from the close of the Agreement or until all evaluations, audits, reviews or investigations or prosecutions are completed, if longer than 10 years. **(§§6.3.3** and **3.10.2.1.11)**

c. Contracted Provider shall give the State or its authorized representative, such as MFCU, any federal oversight agency, such as DHHS and the DOJ, and any other authorized federal agency, including authorized representatives of the federal agency, immediate access to the Contracted Provider's records upon request, including records requested for fiscal audit, medical audit, medical review, utilization review, and other periodic monitoring as well as for administrative, civil and criminal investigations or prosecutions. HIPAA does not bar disclosure of Protected Health Information (PHI) to the State, authorized federal agencies, or authorized representatives of the State or federal agency. **(§§6.3.1** and **3.10.2.1.12)**

d. Contracted Provider shall give the State and/or its authorized representatives and the federal government and/or its authorized representatives during normal business hours the right to enter into the premises of the provider, to inspect, monitor, audit, or otherwise evaluate the work being performed. **(§§6.3** and **3.10.2.1.13)**

e. Contracted Provider shall cooperate with any State or federal inspection, evaluation, review, audit or investigation. **(§3.10.2.1.14)**

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2.12 Health Plan's Obligations to State; Manuals and Handbooks; and Service Denials. Health Plan's responsibilities to the State are as set forth in the State Contract. Provider and its Contracted Providers acknowledges receipt of access to Health Plan's member handbook and Provider Manual. Health Plan will notify Contracted Provider of any denied requests for service authorizations. **(§3.10.2.1.15)**

2.13 Suspension, Termination, and Corrective Action.

a. The Agreement may be suspended by Health Plan if Provider is suspended by the Delaware Medicaid program. **(§§3.16**, **3.10.2.1.16, 3.16.4.9)**

b. The Agreement may be terminated consistent with the termination provisions in the base Agreement and the grounds for termination include: (i) if the provider is terminated from participation in the Delaware Medicaid program, another Medicaid program, or Medicare; (ii) for breach of the Agreement; and (iii) any violation of applicable State or federal law. Health Plan will provide written notice of contract termination in accordance with Section 3.9.16.4 of the State Contract, Network Changes. **(§§3.10.2.1.17** and **3.16.4.10)**

c. Health Plan will monitor the quality of Covered Services delivered under the Agreement and will initiate corrective action where necessary to improve quality of care, in accordance with that level of medical, Behavioral Health, or LTSS that is recognized as acceptable professional practice in the respective community in which Provider practices and/or the standards established by the State. **(§3.10.2.1.18)**

d. Provider and its Contracted Providers will comply with corrective action plans initiated by or requested by Health Plan. **(§3.10.2.1.20)**

e. The main body of the Agreement addresses amending the Agreement. Notwithstanding anything contained in the Agreement to the contrary, in the event the Agreement does not require amendments to be valid only when reduced to writing, duly signed and attached to the original of the Agreement, the Agreement shall allow at least 30 Calendar Days to give notice of rejection and require that receipt of notification of amendments be documented (e.g., certified mail, facsimile, hand-delivered receipt). **(§3.10.2.1.43)**

f. Health Plan may suspend, deny, refuse to renew or terminate the Agreement in accordance with the terms of the State Contract with the State and applicable law and regulation. **(§3.10.2.1.44)**

g. The State reserves the right to direct the Health Plan to terminate or modify the Agreement when the State determines it to be in the best interest of the State. **(§3.10.2.1.45)**

h. Provider and Health Plan recognize that in the event of termination of the State Contract, Provider shall immediately make available to the State, or its designated representative, in a usable form, any or all records, whether medical or financial, related to Provider's activities undertaken pursuant to the Agreement. The provision of such records shall be at no expense to the State. **(§3.10.2.1.46)**

2.14 Cooperation with Policies. Provider will participate in and cooperate with any QM/QI monitoring, UM, Peer Review and/or Appeal procedures established by the Health Plan and/or the State, including any remediation or quality improvement activities. **(§3.10.2.1.19)**

2.15 Emergency Services. Emergency Services shall be rendered without the requirement of prior authorization of any kind. **(§3.10.2.1.21)**

2.16 Confidentiality. Covered Person information shall be kept confidential, in accordance with federal and State law. **(§3.10.2.1.22)**

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2.17 Timely Submission of Reports. Provider and its Contracted Providers shall timely submit all reports and clinical information required by Health Plan. **(§3.10.2.1.23)**

2.18 Prescription Monitoring. Provider and its Contracted Providers shall comply with the requirements of the Delaware Prescription Monitoring Program (PMP), to query the PMP to view information about client usage before prescribing Schedule II or III controlled substances, and to document the results of the query in the Covered Person's record. **(§3.10.2.1.24)**

2.19 Claims Submission and Payment for Covered Services.

a. Health Plan shall only pay Contracted Providers for Covered Services (i) provided in accordance with the requirements of the State Contract, the Health Plan's policies and procedures implementing the State Contract, and State and federal law and (ii) provided to the Health Plan's Covered Person. Moreover, Contracted Provider is responsible for (i) ensuring that any applicable authorization requirements are met and (ii) verifying that a Covered Person is eligible for services on the date of service. **(§3.10.2.1.25)**

b. Contracted Provider shall promptly submit information needed to make payment. Contracted Provider shall have 120 Calendar Days from the date of rendering a Covered Service to file a Claim with the Health Plan except in situations regarding coordination of benefits or subrogation in which case Contracted Provider is pursuing payment from a Third-party or if a Covered Person is Enrolled with Health Plan with a retroactive eligibility date. In situations of Third-party benefits, the maximum timeframes for filing a Claim shall begin on the date that the Third-party documented resolution of the Claim. In situations of Enrollment with Health Plan with a retroactive eligibility date, the timeframes for filing a Claim shall begin on the date that Health Plan receives notification from the State of the Covered Person's eligibility/Enrollment. **(§3.10.2.1.26)**

c. Subject to the "Claims Submission, Processing and Compensation" provisions of the Agreement, Contracted Provider must submit a Clean Claim for reimbursement within 120 Calendar Days from the date of a Covered Service. **(§§3.10.2.1.27** and **3.18.1.1.13)**

d. Health Plan may suspend payment to Contracted Provider if directed by the State. **(§§3.16** and **3.10.2.1.28)**

e. Any physician incentive plan and any other pay for performance programs to which Provider is subject are set forth in the Compensation Schedule(s) and/or or the Provider Manual. **(§3.10.2.1.30)**

f. Provider shall accept payment or appropriate denial made by the Health Plan (or, if applicable, payment by the Health Plan that is supplementary to the Covered Person's Third-party payor) plus the amount of any applicable Covered Person's cost sharing responsibilities, as payment in full for Covered Services or additional services provided and shall not solicit or accept any payment from the Covered Person in excess of the amount of applicable Covered Person cost sharing responsibilities. **(§3.10.2.1.31)**

g. Health Plan will suspend payments to Contracted Provider if the State determines there is a credible allegation of Fraud in accordance with 42 CFR 455.23 or Contracted Provider is excluded from participation **(§§3.11.1.10, 3.16.1.11,** and **3.16.4.8)**

h. If Contracted Provider is compensated via an arrangement other than FFS (e.g., capitation, bundled payment, and shared savings) the following apply: **(§3.10.2.1.32)**

i. If Provider becomes aware for any reason that it is not entitled to a payment for a particular Covered Person (a patient dies, for example), Provider shall immediately notify both the Health Plan and the State by certified mail, return receipt requested **(§3.10.2.1.32.1**); and

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ii. Provider shall promptly submit utilization or Encounter Data as specified by the Health Plan so as to ensure the Health Plan's ability to submit Encounter Data to the State that meets the same standards of completeness and accuracy as required for proper adjudication of FFS Claims. **(§3.10.2.1.32.2)**

2.20 Program Integrity. Provider and its Contracted Providers shall comply with program integrity requirements described in Section 3.16 of the State Contract, including, but not limited to:

a. identification and reporting of suspected Fraud, Waste and Abuse ("FWA"). **(§3.10.2.1.33)**

b. complying with Health Plan's FWA policies and procedures **(§§3.16.1.1)**

c. complying with all federal and State law regarding FWA, including, but not limited to, Sections 1128, 1128J(d), 1156, 1902(a)(39), 1902(a)(68), 1866(j)(5), 1903 and 1932(d)(1) of the Social Security Act and 42 CFR Parts 431, 433, 434, 435, 438, 441, 447, 455 and 1001. **(§3.16.1.2)**

d. maintaining Enrollment in Delaware Medical Assistance Program (DMAP) (and complying with related requirements). **(§3.16.1.3)** Health Plan will not make payment to Contracted Provider if Contracted Provider is not enrolled with DMAP, except as otherwise provided in Section 3.9.8 of the State Contract captioned, "Provider Screening and Enrollment with DMAP." **(§3.11.1.6)**

e. In accordance with Section 1932(d)(1) of the Social Security Act and 42 CFR 438.610, the Provider shall not be or become debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation (FAR) or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order 12549 or be affiliated, as defined in the FAR at 48 CFR 2.101, of such an entity or individual. Moreover, Provider shall not be an individual or an entity that is excluded from participation in any federal health care program under Section 1128 or 1128A of the Social Security Act. Provider shall immediately notify Health Plan in writing of any such circumstance. **(§3.16.2.1)**

f. Provider and its Contracted Providers shall cooperate with any and all FWA investigations of Health Plan. **(§3.16.4)**

2.21 Overpayments. Provider shall comply with federal and State policy regarding overpayments, including, but not limited to, reporting overpayments and, when it is applicable, returning overpayments to the Health Plan within 60 Calendar Days from the date the overpayment is identified. Overpayments that are not reported and returned within 60 Calendar Days from the date the overpayment was identified may result in a penalty pursuant to State or federal law. **(§§3.10.2.1.34** and **3.16.5)**

2.22 Assignment of State Funds/Payments. Any reassignment of payment by Provider must be made in accordance with all 42 CFR 447.10. Provider shall not be permitted to assign State funds/payments to billing agents or alternative payees without executing a billing agent or alternative payee assignment agreement. Provider must ensure that billing agents and alternative payees are subject to initial and monthly federal exclusion (LEIE) and debarment (SAM) screening if the alternative payee assignment is on-going. Further, direct and indirect payments to out of country individuals and/or entities are prohibited. **(§§3.10.2.1.35** and **3.11.1.7)**

2.23 Exclusion Screening. Provider shall screen its employees and contractors initially and on an ongoing monthly basis to determine whether any of them has been excluded from participation in Medicare, Medicaid, CHIP, or any federal health care programs (as defined in Section 1128B(f) of the Social Security Act) and not employ or contract with an individual or entity that has been excluded or debarred. Provider must immediately report to the Health Plan any exclusion information discovered. Provider is aware that civil monetary penalties may be imposed by the State

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or federal government against providers who employ or enter into contracts with excluded individuals or entities to provide items or services to Covered Persons. **(§3.10.2.1.36)**

2.24 Certification of Compliance. Provider understands and agrees that each Claim the Provider submits to the State or the Health Plan constitutes a certification that the Provider has complied with all applicable federal and State law (including, but not limited to, the federal Anti-Kickback Statute and the Stark Law) and program requirements, in connection with such Claims and the services provided therein. **(§3.10.2.1.37)**

2.25 Obligation to Report & Notify.

a. Provider shall report suspected Abuse, neglect and financial exploitation of Adults and suspected Abuse or neglect of children in accordance with State law. **(§3.10.2.1.38)**

b. For DSHP Plus LTSS Covered Persons, Provider shall facilitate notification of the Covered Person's case manager by notifying the Health Plan, in accordance with the Health Plan's processes, as expeditiously as warranted by the Covered Person's circumstances, of any known significant changes in the Covered Person's condition or care, hospitalizations, or recommendations for additional services. **(§3.10.2.1.39)**

c. For Covered Persons participating in PROMISE, Provider shall facilitate notification of the Covered Person's DSAMH care manager by notifying DSAMH, in accordance with DSAMH's processes, as expeditiously as warranted by the Covered Person's circumstances, of any known significant changes in the Covered Person's condition or care, hospitalizations, or recommendations for additional services. **(§3.10.2.1.40)**

2.26 Insurance. Provider shall secure all necessary liability and malpractice insurance coverage as is necessary to adequately protect the Health Plan's Covered Persons and the Health Plan under the Agreement. Provider shall maintain such insurance coverage at all times during the term of the Agreement and upon execution of the Agreement furnish the Health Plan with written verification of the existence of such coverage. **(§3.10.2.1.41)**

2.27 Conflict of Interest. Provider agrees to the following: **(§§3.10.2.1.47** and **6.12.3)**

a. No official or employee of the State of Delaware or the federal government who exercises any functions or responsibilities in the review or approval of the undertaking or carrying out of the State Contract or the Enrollment processes specified in 42 CFR 438.54(b) shall voluntarily acquire any personal interest, direct or indirect, in the Agreement.

b. Provider represents and covenants that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of its services under the Agreement. Provider further covenants that, in the performance of the Agreement, no person having any such known interests shall be employed.

c. In accordance with 42 CFR 438.604(a)(6), Provider shall disclose information on individuals, entities, or corporations with an ownership or control interest in Provider (as described in 42 CFR 455.104) and any Subcontractors/Downstream Entities to the State at the time required by Applicable Law.

d. The Agreement may be terminated by Health Plan and/or the State if it is determined that Provider, its officers, agents, employees, or Subcontractors/Downstream Entities offered or gave wages, compensation, gratuities or gifts of any kind to any officials or employees of the State of Delaware.

e. Provider certifies that no member of or delegate to Congress, or employee of any federal agency has or will benefit financially or materially from the Agreement.

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f. In the event that the Agreement is terminated under this section, Health Plan and/or State shall be entitled to pursue the same remedies against Provider as it could pursue in the event of a breach of the Agreement by Provider.

g. The rights and remedies provided for in this section of the are in addition to any rights and remedies provided under law.

2.28 Lobbying. By signing the Agreement, Provider certifies, to the best of its knowledge and belief, that federal funds have not been used for lobbying as prohibited by 31 USC 1352 and 45 CFR Part 93. Provider shall disclose any lobbying activities using non-federal funds in accordance with 45 CFR Part 93. **(§§3.10.2.1.47** and **6.1.13)**

2.29 Indemnification. In accordance with the same terms and conditions of Section 6.6 of the State Contract (under which Health Plan indemnifies, defends, protects and holds harmless the State of Delaware (and the other identified persons)), at all times during the term of the State Contract, Provider shall indemnify and hold harmless the State of Delaware (and those same identified persons) from all claims, losses, or suits relating to activities undertaken pursuant to the State Contract. Those provisions of Section 6.6 of the State Contract are incorporated herein in its entirety. **(§3.10.2.1.48)**

2.30 Provider Preventable Conditions (PPCs).

a. In accordance with 42 CFR 438.3(g): (i) as a condition to payment by Health Plan, Provider shall identify and report to Health Plan all PPCs and shall report in Encounter Data all PPCs (as set forth in 42 CFR 434.6(a)(12) and 42 CFR 447.26); and (ii) Health Plan will not pay for PPCs. **(§§3.10.2.1.49** and **3.11.4.1)**

b. Health Plan will not pay for PPCs, as defined in DMMA's policy manual, unless they fall into one of the two exceptions: **(§3.11.4.2)**

i. Health Plan will not impose a reduction in payment for a PPC when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by Provider. **(§3.11.4.2.1)**

ii. Health Plan may limit reductions in payment to Provider to the extent that the following apply: **(§3.11.4.2.2)**

A. The identified PPC would otherwise result in an increase in payment. **(§3.11.4.2.2.1)**

B. Health Plan can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the PPC. **(§3.11.4.2.2.2)**

c. Provider agrees to comply with the reporting requirements in 42 CFR 447.26(d) as a condition of payment from Health Plan. Provider shall identify PPCs that are associated with Claims (see Section 3.18.4 of the State Contract). (**§3.11.4.2.3**)

2.31 Imposition of Sanctions. In addition to any other express rights of Health Plan as may be set forth in the Agreement, in the event of a failure by Provider to comply with the requirements of the Agreement, including, but not limited to, Provider's failure or refusal to respond to the Health Plan's request for information such as medical records, Health Plan may exercise its termination rights as set forth in the applicable sections of the Agreement. At the Health Plan's discretion or as directed by the State, the Health Plan shall impose financial consequences against the Provider as appropriate. **(§3.10.2.1.50)**

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2.32 Prohibition Against Promoting State Custody. Provider is not permitted to encourage or suggest, in any way, that children be placed into State custody in order to receive medical, behavioral, or LTSS benefits covered by the State. **(§3.10.2.1.51)**

2.33 Non-Discrimination. Provider shall comply with the following non-discrimination provisions:

a. No person on the grounds of handicap, disability, age, race, color, religion, sex, national origin, or any other status protected by federal or State law, shall be excluded from participation in, or be denied benefits of, or be otherwise subjected to discrimination in the performance of Provider's obligation under the Agreement or in the employment practices of the Provider. **(§3.10.2.1.53.1)**

b. Provider has written procedures for the provision of language interpretation services for any Covered Person who needs such services, including, but not limited to, Covered Persons with Limited English Proficiency (LEP). **(§3.10.2.1.53.2)**

2.34 Marketing Materials. Provider shall not use the State's name or logos for any materials intended for dissemination to Covered Persons unless said material has been submitted to the State by the Health Plan for review and has been approved by the State. This prohibition shall not include references to whether or not Provider accepts Medicaid. **(§3.10.2.1.54)**

2.35 Third-party Liability (TPL). Consistent with the provisions of Section 3.18.3 of the State Contract**,** Provider is responsible for (i) identifying TPL coverage, including Medicare and long-term care insurance as applicable and, (ii) except as otherwise provided in the Health Plan's contract with the State, to seek such TPL payment before submitting Claims to the Health Plan. This obligation includes the obligation to utilize or pursue, when available, other Third-party coverage from such sources as private commercial insurance, military health insurance, and Medicare. This responsibility includes identification and pursuit of Third-party payment for Covered Services provided that may be related to an accidental injury, medical malpractice or any other cause for legal action, including Claims identified from Health Plan's review of Claims with diagnosis codes indicative of trauma, injury, poisoning, and other consequences of external causes. This also includes seeking payment from vehicle and homeowner's insurance for accident and trauma cases that occur while an individual is enrolled with Health Plan. If the probable existence of TPL has been established at the time the Claim is received, Health Plan will reject the Claim and return it to the Provider for a determination of the amount of any TPL. **(§3.10.2.1.55)**

2.36 Critical Incident Reporting. Provider and its Contracted Providers shall comply with Health Plan's Provider Manual with respect to the reporting of Critical Incidents. **(§3.9.7.3.5.20)**

2.37 Payment in Full. As a condition of payment, Provider shall accept the amount paid by the Health Plan or appropriate denial made by the Health Plan (or, if applicable, payment by the Health Plan that is supplementary to the Covered Person's Third-party payor) plus any applicable amount of cost sharing or Patient Liability responsibilities due from the Covered Person as payment in full for the service. **(§3.11.1.4)**

2.38 Hold Harmless. Provider shall hold the Covered Person harmless for the costs of Medically Necessary Covered Services and additional services except for applicable copayment amounts (see Section 3.4.9.1 of the State Contract) and Patient Liability amounts (see Section 3.4.9.2 of the State Contract). **(§3.11.1.5)**

2.39 Payment via Electronic Transfers. For any payment via electronic transfers, Health Plan must have a signed Electronic Funds Transfer (EFT) form that shall have 42 CFR 455.18 and 42 CFR 455.19 statements immediately preceding the "Signature" section. **(§3.11.1.9)**

2.40 Service Authorizations. Provider shall comply with Health Plan's policies and procedures for service authorizations. **(§3.12.8)**

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2.41 Grievance and Appeal System. Provider acknowledges receipt from Health Plan, as set forth in the Provider Manual, information regarding the procedures and timeframes for the Grievance and Appeal System which such information includes: the right to file Grievances and Appeals, the requirements and timeframes for filing; the availability of assistance in the filing process; the right to request a State fair hearing in the event of an adverse determination; and the fact that, when requested by Covered Person, benefits that Health Plan seeks to reduce or terminate will continue if the Covered Person files an Appeal or a request for State fair hearing with the timeframes specified and that the Covered Person may, consistent with state policy, be required to pay the cost of the services furnished while the Appeal or State fair hearing is pending if the final decision is adverse to the Covered Person. **(§§ 3.9.7.3.5.31** and **3.15.6)**

2.42 Non-Payment. Health Plan will not pay for the following:

a. In accordance with Section 1902(a)(80) of the Social Security Act and 42 CFR 438.602(i), Health Plan will not make any payments for Covered Services or additional services to Provider located outside of the United States. **(§3.11.1.8)**

b. for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under title V, XVIII, or XX or under this title pursuant to Section 1128, 1128A, 1156, or 1842(j)(2) and when the person furnishing such item or service knew, or had reason to know, of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person). **(§3.11.1.10)**

c. for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished by Provider if the State has failed to suspend payments during any period when there is a pending investigation of a credible allegation of Fraud against Provider, unless the State determines there is good cause not to suspend such payments. **(§3.11.1.11)**

d. for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) with respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997. **(§3.11.1.12)**

e. for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) with respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under the Delaware Medicaid State Plan. **(§3.11.1.13)**

f. for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) for home health care services provided by Provider, unless Provider provides the State with a surety bond as specified in Section 1861(o)(7) of the Act. **(§3.11.1.14)**

2.43 Unique Obligations of Hospitals.

a. If Provider is a hospital, including a psychiatric hospital, Provider shall cooperate with the Health Plan in developing and implementing protocols as part of the Health Plan's nursing facility diversion plan, which such plan shall, at a minimum, require Provider: (i) to promptly notify the Health Plan upon admission of an eligible Covered Person regardless of payor source for the hospitalization; (ii) the method by which Provider will identify Covered Persons who may need home health, nursing facility, or HCBS, including assisted living, upon discharge, and (iii) the method by which Provider will engage the Health Plan and other providers in the discharge planning process to ensure that Covered Persons receive the most appropriate and cost-effective Medically Necessary services upon discharge. **(§3.10.2.1.56)**

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b. If Provider is a hospital, including a psychiatric hospital, Provider shall (i) cooperate with the Health Plan in implementing an inpatient Behavioral Health UM strategy to reduce inpatient utilization; (ii) in admitting Covered Persons for acute Behavioral Health treatment Provider shall collaborate with identified outpatient Behavioral Health providers and, within 24 hours of admission, complete a comprehensive assessment including an assessment of anticipated discharge needs. **(§3.10.2.1.57)**

2.44 Unique Obligations of PCPs. PCPs are limited to advanced nurse practitioners, nurse midwives and licensed physicians who are family or general practitioners, geriatricians, pediatricians, OB/GYNs or internists. **(§3.9.10.2)** If Provider is a PCP, Provider shall also: **(§§ 3.8.12.3, 3.9.10.1** and **3.10.2.1.58)**

a. Maintain continuity of each member's health care by serving as the member's PCP;

b. Provide access 24 hours a day, 7 days a week;

c. Facilitate appropriate member referral to specialty care and other Medically Necessary services not provided by the PCP;

d. Make an early detection of a child member's problems in development, behavior, social-emotional skills or mental health status, including the use of a reliable and validated screening tool prior approved by the Health Plan, and make appropriate referrals to address any identified problems;

e. Make an early identification of Behavioral Health needs, including the use of a reliable and validated screening tool prior approved by the Health Plan, and make appropriate referrals to address Behavioral Health needs, including referral to PROMISE as appropriate;

f. For DSHP Plus LTSS members, engage with the member's case manager at least quarterly and as needed to address member care issues;

g. Maintain a current medical record for the member, including documentation of all services provided to the member by the PCP as well as any specialty or referral services and report;

h. Adhere to the State's EPSDT periodicity schedule and EPSDT referral requirements for members under age 21;

i. Follow the Health Plan's procedures for coordination of in-network and out-of-network services for members; and

j. Cooperate with all QM/QI initiatives and programs established by the Health Plan or the State.

k. Enroll with DPH to receive vaccines covered by the Vaccines for Children (VFC) program and use the free vaccine for its child Covered Persons. Provider shall report all immunizations (not only vaccines covered by the VFC program) to the DPH Immunization Registry.

2.45 Unique Obligations of Public Health Service Entities. If Provider is a public health service entity, Provider must obtain permission from the State in order to submit Claims to the Health Plan for drugs purchased through the 340B drug discount program. **(§3.10.2.1.60)**

2.46 Unique Obligations of Nursing Facilities. If Provider is a nursing facility, the following provisions shall also apply: **(§3.10.3.1)**:

a. Provider shall promptly notify the Health Plan, and/or other entity as directed by the State, of a Covered Person's admission or request for admission to the nursing facility regardless of payor source for

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the nursing facility stay, or when there is a change in a Covered Person's known circumstances and Provider shall notify the Health Plan, and/or entity as directed by the State, prior to a Covered Person's discharge. **(§3.10.3.1.1)**

b. Provider shall provide written notice to the State and the Health Plan in accordance with State and federal requirements before voluntarily terminating the Agreement and Provider shall comply with all applicable State and federal requirements regarding voluntary termination. **(§3.10.3.1.2)**

c. Provider shall notify the Health Plan immediately when considering discharging a Covered Person and Provider shall consult with the Covered Person's case manager to intervene in resolving issues if possible and, if not, to prepare and implement a discharge and/or transition plan as appropriate. **(§3.10.3.1.3)**

d. Provider shall not request that a Covered Person leave after their Medicare benefit days have been exhausted. **(§3.10.3.1.4)**

e. Provider shall notify the Covered Person and/or the Covered Person representative (if applicable) in writing 30 Calendar Days prior to discharge in accordance with State and federal requirements (see, e.g., 42 CFR 483.15), and Health Plan will notify the nursing facility in writing 30 Calendar Days prior to a Covered Person leaving the facility. **(§3.10.3.1.5)**

f. Provider shall accept payment or appropriate denial made by the Health Plan (or, if applicable, payment by the Health Plan that is supplementary to the Covered Person's Third-party payor) plus the amount of any applicable Patient Liability, as payment in full for services provided and shall not solicit or accept any payment from the Covered Person in excess of the amount of applicable Patient Liability responsibilities. **(§3.10.3.1.6)**

g. Provider shall: (i) collect the applicable Patient Liability amounts from Covered Persons, (ii) notify the Covered Person's case manager if there is an issue with collecting a Covered Person's Patient Liability, and (iii) make good faith efforts to collect payment. For a Covered Person in an Assisted Living Facility, the amount of Patient Liability assessed applies only to the cost of HCBS, not to the cost of Covered Services available under the Medicaid Program. If a Covered Person refuses to pay their Patient Liability, Provider may notify Health Plan that Provider is terminating services to the Covered Person. **(§§3.4.9.1, 3.4.9.2,** and **3.10.3.1.7)**

h. Provider shall notify the Health Plan of any change in a Covered Person's medical or functional condition that could impact the Covered Person's Level of Care for the currently authorized level of nursing facility services. **(§3.10.3.1.8)**

i. Provider shall comply with State and federal law applicable to nursing facilities, including, but not limited to, those that govern admission, transfer, and discharge policies. **(§3.10.3.1.9)**

j. Provider shall comply with Federal Preadmission Screening and Resident Review (PASRR) requirements, including that a Level I screening be completed prior to admission, a Level II evaluation be completed prior to admission when indicated by the Level I screening, and a review be completed based upon a significant physical or mental change in the resident's condition that might impact the Covered Person's need for or benefit from Specialized Services. **(§3.10.3.1.10)**

k. Provider shall cooperate with the Health Plan in developing and implementing protocols as part of the Health Plan's nursing facility diversion and transition processes (see Sections 3.8.5 and 3.8.6 of the State Contract). These processes include, at a minimum, Provider's obligation: (i) to promptly notify the Health Plan upon admission or request for admission of an eligible Covered Person regardless of payor source for the nursing facility stay; (ii) to provide a minimum data set (MDS) of information; (iii) the method by

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which Provider will assist the Health Plan in identifying residents who may want to transition from nursing facility services to home and community-based care; (iv) to promptly notify the Health Plan regarding all such identified Covered Persons; (v) the method by which Provider will work with the Health Plan in assessing the Covered Person's transition potential and needs, and in developing and implementing a transition plan, as applicable. **(§3.10.3.1.11)**

l. Provider shall coordinate with Health Plan in complying with the requirements in 42 CFR 483.70(j) regarding written transfer agreements with hospitals and to use providers when transfer is medically appropriate, except as authorized by the Health Plan or for Emergency Services. **(§3.10.3.1.12)**

m. Provider shall immediately notify the Health Plan of any change in its license to operate as issued by the State as well as any deficiencies cited during the federal certification process. **(§3.10.3.1.13)**

n. If Provider is involuntarily decertified by the State or CMS, the Agreement will automatically be terminated in accordance with federal requirements. **(§3.10.3.1.14)**

o. The Agreement shall be assignable from the Health Plan to the State, or its designee, at the State's discretion upon written notice to the Health Plan and Provider. Further, Provider agrees to be bound by any such assignment, and the State, or its designee, shall not be responsible for past obligations of the Health Plan. **(§3.10.3.1.15)**

p. Provider must provide at least the same array of Covered Services as covered by the State's Medicaid FFS program with Medicare/Medicaid certified nursing facilities. **(§3.9.11.7.1)**

2.47 Unique Obligations of HCBS Providers. If Provider is a HCBS Provider, the following shall also apply: **(§3.10.4.1)**

a. Provider shall provide at least 30 Calendar Days advance notice to the Health Plan when Provider is no longer willing or able to provide services to a Covered Person, including the reason for the decision, and Provider shall cooperate with the Covered Person's case manager to facilitate a seamless transition to alternate providers. **(§3.10.4.1.1)**

b. In the event that an HCBS provider change is initiated for a Covered Person, regardless of any other provision in the Agreement, if Provider is the transferring HCBS provider, Provider must continue to provide services to the Covered Person in accordance with the Covered Person's plan of care until the Covered Person has been transitioned to a new provider, as determined by the Health Plan, or as otherwise directed by the Health Plan, which may exceed 30 Calendar Days from the date of notice to the Health Plan. **(§3.10.4.1.2)**

c. Reimbursement of Provider is contingent upon the provision of Covered Services to an eligible Covered Person in accordance with applicable federal and State requirements and the Covered Person's plan of care as authorized by the Health Plan. Moreover, a Claim for reimbursement must be supported by detailed documentation of service delivery to support the amount of services billed, including at a minimum, the date, time and location of service, the specific HCBS provided, the name of the Covered Person receiving the service, the name of the staff person who delivered the service, the detailed tasks and functions performed as a component of each service, notes for other Caregivers (whether paid or unpaid) regarding the Covered Person or their needs (as applicable), and the initials or signature of the staff person who delivered the service. **(§3.10.4.1.3)**

d. Provider shall comply with the State's electronic visit verification (EVV) requirements. **(§3.10.4.1.4)**

e. Provider shall immediately report any deviations from a Covered Person's service schedule to the Covered Person's case manager. **(§3.10.4.1.5)**

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f. Upon acceptance by Provider to provide approved services to a Covered Person as indicated in the Covered Person's plan of care, Provider shall ensure that it has staff sufficient to provide the service(s) authorized by the Health Plan in accordance with the Covered Person's plan of care, including the amount, frequency, duration and scope of each service in accordance with the Covered Person's service schedule. **(§3.10.4.1.6)**

g. Provider shall provide back-up for its own staff if they are unable to fulfill their assignment for any reason and ensure that back-up staff meet the qualifications for the authorized service. **(§3.10.4.1.7)**

h. Provider is prohibited from requiring a Covered Person to choose Provider as a provider of multiple services as a condition of providing any service to the Covered Person. **(§3.10.4.1.8)**

i. Provider may not solicit Covered Persons to receive services from Provider including **(§3.10.4.1.9)**:

i. Communicating with existing HCBS Covered Persons via telephone, in-person or written communication for the purpose of petitioning the Covered Person to change HCBS providers **(§3.10.4.1.9.1)**; or

ii. Communicating with hospitals, discharge planners or other institutions for the purposes of soliciting potential HCBS Covered Persons that should instead be referred to Health Plan, as applicable **(§3.10.4.1.9.2)**.

j. Provider shall comply with Critical Incident reporting requirements as set forth in Health Plan's Provider Manual. **(§§3.9.7.3.5.20, 3.10.4.1.10** and **3.13.10)**.

k. Provider shall comply with all applicable federal requirements for HCBS settings requirements (including but not limited to 42 CFR 42 441.301(c)(4)). **(§3.10.4.1.11)**

2.48 Unique Obligations of FQHCs. If Provider is a FQHC, Provider must provide data on all Covered Services provided to a Covered Person. **(§3.9.11.2.2)**

2.49 Unique Obligations of SBWCs. If Provider is a School-Based Wellness Center, Provider will provide at least the same array of Covered Services covered by the State's Medicaid FFS program with Provider. **(§3.9.11.3)**

2.50 Unique Obligations of Mobile Vision Providers. If Provider is a Mobile Vision Provider, Provider will provide at least the same array of Covered Services covered by the State's Medicaid FFS program with Provider. **(§3.9.11.4)**

2.51 Unique Obligations of Behavioral Health Crisis Providers. If Provider is a Behavioral Health Crisis Provider, Provider shall comply with all Health Plan's protocols relating to notification of Covered Person engagement and shall ensure appropriate follow-up with Covered Persons occurs within 72 hours of the initial engagement with Provider. **(§3.9.11.6)**

2.52 Unique Obligations of Behavioral Health Providers. If Provider is a Behavioral Health Provider, Provider shall: **(§3.9.13)**

a. Utilize Primary Care prevention strategies; recovery oriented and Trauma-Informed Care approaches; validated screening tools; early screening, identification and interventions; and enhanced discharge planning and follow-up care when members are hospitalized or placed in an institutional setting.

b. Engage in practices which integrate Behavioral Health and physical health services.

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c. Engage in practices which consider and address HRSN, provide Culturally Competent care and maximize member and family care preferences.

2.53 Unique Obligations of Providers of LTSS for DSHP Plus LTSS Covered Persons. If Provider is a Provider of LTSS for DSHP Plus LTSS Covered Persons, the time between service authorization by Health Plan to service implementation shall be as follows: **(§3.9.14)**

a. No more than 60 Calendar Days for minor home modifications;

b. No more than 10 Calendar Days for home delivered meals;

c. No more than 10 Calendar Days for personal care attendant services for new members; and

d. Immediately upon authorization for personal care attendant services for members currently placed in a nursing facility and transitioning to the community other than to assisted living.

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SCHEDULE B
STATE-MANDATED REGULATORY REQUIREMENTS

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

DE-1. No definition or provision of the Agreement shall be construed to conflict with the definitions or provisions contained in Title 18, Chapter 1403 of the Delaware Administrative Code. (18 DEL. ADMIN. CODE 1403-7.3.) Except or unless as otherwise provided under applicable Regulatory Requirements, "Medical Necessity" for the purposes of these "State-Mandated Regulatory Requirements" shall mean, as set forth in 18 Del. Admin. Code 1403-2.0, providing of covered health services or products that a prudent physician would provide to a patient for the purpose of diagnosing, or treating an illness, injury, disease or its symptoms in a manner that is (a) in accordance with generally accepted standards of medical practice; (b) consistent with the symptoms or treatment of the condition; and (c) not solely for anyone's convenience.

DE-2. The following shall apply:

a. Provider agrees that in no event, including but not limited to non-payment by Health Plan or intermediary, insolvency of Health Plan or intermediary, or breach of the Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Covered Person or a person (other than Health Plan or intermediary) acting on behalf of the Covered Person for services provided pursuant to the Agreement. The Agreement does not prohibit Provider from collecting coinsurance, deductibles or co-payments, as specifically provided in the evidence of coverage, or fees for non-Covered Services delivered on a fee-for-service basis to Covered Persons. (18 DEL. ADMIN. CODE 1403-7.1.1)

b. In the event of Health Plan's or intermediary's insolvency or other cessation of operations, Covered Services to Covered Persons will continue through the period for which a premium has been paid to Health Plan on behalf of the Covered Person or until the Covered Person's discharge from an inpatient facility, whichever time is greater. Covered Services to Covered Persons confined in an inpatient facility on the date of insolvency or other cessation of operations will continue until their continued confinement in an inpatient facility is no longer Medically Necessary. (18 DEL. ADMIN. CODE 1403-7.1.2)

c. The foregoing provisions shall be construed in favor of the Covered Person, shall survive the termination of the Agreement regardless of the reason for termination, including the insolvency of Health Plan, and shall supersede any oral or written contrary agreement between Provider and a Covered Person or the representative of a Covered Person if the contrary agreement is inconsistent with the hold harmless and continuation of Covered Services provisions required by paragraphs 5(a) and 5(b) above. (18 DEL. ADMIN. CODE 1403-7.2)

DE-3. Nothing in the Agreement shall be construed as an offer of incentives to Provider to provide less than Medically Necessary services to a Covered Person. (18 DEL. ADMIN. CODE 1403-10.0)

DE-4. Except in cases where termination was due to unsafe health care practices that compromise the health or safety of Covered Persons, Provider shall continue to provide Covered Services, at the rates set forth in the Agreement, for up to 120 calendar days following notification of termination in cases where it is Medically Necessary for the Covered Person to continue treatment with Provider. In cases of the pregnancy of a Covered Person, Medical Necessity shall be deemed to have been demonstrated and coverage shall continue to completion of postpartum care. (18 DEL. ADMIN. CODE 1403-9.3; 1403-2.0)

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DE-5. Provider shall maintain or provide for the maintenance of a medical records system that meets the accepted standards of the health care industry and State and federal regulations, including provision for sufficient space and equipment for the processing and safe storage of records and for protection from loss, damage and unauthorized use. With the exception of medical records of minors (individuals under the age of 18 years), Provider shall provide for the preservation of medical records as original records, on microfilm or electronically stored for no less than five years after the most recent patient care usage, after which time records may be destroyed at the discretion of Health Plan; medical records of minors shall be preserved for the period of minority plus five years (i.e., 23 years) or as otherwise required by State law. Provider shall provide the DHSS with access to medical records for purposes of monitoring and review of MCO practices. (18 DEL. ADMIN. CODE 1403-12.1)

DE-6. Provider acknowledges that any significant amendment to or revision relating to the text or subtext of the Agreement, once approved, shall be submitted to and approved by the DHSS prior to the execution. (18 DEL. ADMIN. CODE 1403-12.2)

DE-7. Nothing in the Agreement shall be construed as a provision or non-disclosure clause prohibiting Provider from giving Covered Persons information regarding diagnoses, prognoses and treatment options. (18 DEL. C. §6414)

DE-8. Health Plan shall not refuse to compensate Provider for Covered Services solely because Provider has in good faith communicated with one or more of Provider's current, former or prospective patients regarding the provisions, terms, or requirements of Health Plan's products or services as they relate to the needs of Provider's patients. (18 DEL. C. §6415)

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