CARE MANAGEMENT SERVICES AGREEMENT

Aetna Better Health Inc. dba Aetna Better Health of Ohio, on behalf of itself and its Affiliates ("Company"), and ______________________________ ("Service Provider" or "CME"), on behalf of itself and Network Providers, enter into this Care Management Services Agreement (the "Agreement"), as of the Effective Date set forth below.

WHEREAS, Service Provider does not itself provide medical care or treatment but is a care management entity that provides access to a network of contracted Network Providers that provide mental health and behavioral care and treatment;

WHEREAS, Service Provider is authorized to negotiate and enter into this Agreement on behalf of Network Providers and to bind them to the terms hereof;

WHEREAS, Company was selected by the Ohio Department of Medicaid (ODM) to implement the Ohio Resilience through Integrated Systems and Excellence program ("OhioRISE Program"), serving as the specialized managed care organization for the state's children with the most complex behavioral health needs through offering and administering the OhioRISE Plan ("OhioRISE Plan");

WHEREAS, Service Provider will serve as Company's implementing partner for the OhioRISE Program within Service Provider's Catchment Area in the delivery of Intensive Care Coordination (ICC) and Moderate Care Coordination (MCC);

WHEREAS, Service Provider desires to provide Company, with: (a) access to a network of Network Providers; (b) related administrative services; (c) community resource development; and (d) Intensive Care Coordination (ICC) and Moderate Care Coordination (MCC) using High-Fidelity Wraparound, all as defined and described in this Agreement.

WHEREAS, Company desires to obtain such network and services from and/or delegate to Service Provider, as more fully described in this Agreement.

NOW THEREFORE, for good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the Parties hereby agree as follows:

EFFECTIVE DATE: [DATE]

TERM: This Agreement begins on the Effective Date, continues for an initial term of [one (1) year], and then automatically renews for consecutive one (1) year terms, but in any case shall conform with the terms of Company's contract for the OhioRISE Program. The Agreement may be terminated by either Party at any time after the initial term, or non-renewed at the end of the initial or any subsequent term, for any reason or no reason at all, with at least [one hundred and eighty (180)] days' advance written notice to the other Party. Additional termination provisions are included in this Agreement.

PRODUCT CATEGORIES:

As of the Effective Date, Service Provider agrees to participate in each Product Category checked below. Important information on how Product Categories can be added to or deleted from this list is contained in this Agreement.

✓ **Medicaid Products (See Exhibit A – Affiliate Listing & Product Participation)**

The undersigned representative of Service Provider agrees that it has read and understood this Agreement, has had the opportunity to review it with an attorney of its choice, and is authorized to bind Service Provider, as well as all Network Providers, to the terms of this Agreement.

SERVICE PROVIDER	**COMPANY**
By:______________________________	**By:**______________________________
Printed Name:____________________	**Printed Name:**____________________
Title:___________________________	**Title:**___________________________

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FEDERAL TAX I.D. NUMBER:_______

As required by Section 9.7 ("Notices") of this Agreement, notices shall be sent to the following addresses:

Service Provider:

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Company:

Aetna Better Health Inc. dba Aetna Better Health of Ohio

7400 West Campus Road

New Albany, OH 43054

ATTN: Plan Chief Executive Officer

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AGREEMENT COMPONENTS/EXHIBITS

In addition to the **Signature Page** above, the **General Terms and Conditions** that follow, and the **Medicaid Product Addendum**, the Agreement includes the following Exhibits which include additional terms and conditions applicable to the Agreement:

Exhibit A – Affiliate Listing & Product Participation

Exhibit B – Service and Rate Schedule (Medicaid Products)

Exhibit C – State Compliance Addenda (Medicaid Products/Ohio RISE)

[INCLUDE THE BELOW EXHIBITS, AS APPLICABLE]

Exhibit D – Performance Guarantees [/Metrics/Network Access and Accessibility Requirements] (Medicaid Products)

Exhibit E – Business Associate Agreement (including Data Security and Access requirements, as applicable)

Exhibit F – Delegated Services Addendum

Exhibit G – Value-Based Solutions Addendum - [Insert name of VBS Addenda, if any]

Exhibit _____ Reporting

Exhibit_____ Individual Sites/Network Provider Locations - OR - Network Provider Exceptions

Exhibit _____ Designation of Payment Attestation which Service Provider must obtain from each Network Provider.**]**

Exhibit _____ Letter of Credit [or other Financial Protection exhibit]

Exhibit_____ Administrative Services

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GENERAL TERMS AND CONDITIONS

1.0 AUTHORITY REGARDING NETWORK PROVIDERS.

1.1 **Negotiating Authority**. Service Provider agrees to operate, maintain, and provide access to the Network of Network Providers and services in accordance with the terms of this Agreement. Service Provider agrees, represents and warrants that, throughout the term of this Agreement, it:

(a) is authorized to negotiate and enter into this Agreement on behalf of all Network Providers and to bind them to its terms;

(b) will maintain a valid, written Network Provider Contract, with each Network Provider, that describes the relationship between Service Provider and each Network Provider, and requires compliance with the applicable terms of this Agreement. Service Provider will provide Company with a copy of any such Network Provider Contract(s), upon Company's request;

(c) will maintain a Business Associate Agreement as defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") with all non-employed Network Providers pursuant to which it is and will remain a business associate of such providers; and

(d) will enforce Network Providers' obligations to comply with the terms of the Agreement.

1.2 **Covered Services**. Service Provider provides access to a network of Network Providers that provide certain ICC and MCC Covered Services. Service Provider agrees that it will require all Network Providers to provide Covered Services (including, but not limited to, any related facilities, equipment, personnel and/or other resources necessary to provide the Covered Services) according to generally accepted standards of care in the applicable geographic area and, as applicable, within the scope of their licenses, registrations and/or other required authorizations.

2.0 SERVICE PROVIDER AND NETWORK PROVIDER OBLIGATIONS.

2.1 **General Obligations**.

2.1.1 Service Provider agrees that it will and will require each Network Provider to:

(a) obtain and maintain any and all applicable license(s), certification(s), registration(s), authorization(s) and accreditation(s) required by Applicable Law;

(b) comply with all Applicable Law related to this Agreement and the provision of and payment for Covered Services; Service Provider represents that neither it nor any Network Provider has been excluded from participation in any Federal or state funded program or has a report filed in the National Practitioner Data Bank (NPDB);

(c) comply with Company's applicable credentialing/recredentialing requirements and applicable Participation Criteria; Service Provider understands that no Network Provider may serve as a Participating Provider until that provider is fully credentialed and, for health care providers, approved by the applicable peer review committee;

(d) require all Network Providers in all Individual Sites and Network Provider locations, to provide services to Members in accordance with the terms and rates of this Agreement; any exceptions (e.g., excluded locations or providers) must be approved in advance, in writing, by Company;

(e) obtain from Members any necessary consents or authorizations to the release of their medical and/or other personal information and records to governmental entities, Company and Payers, and their agents and representatives;

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(f) obtain signed assignments of benefits from all Members authorizing payment to be made directly to Service Provider or Network Providers, as the case may be, instead of to the Member, unless Company specifically directs otherwise or the applicable Plan requires otherwise;

(g) (i) treat all Members with the same degree of care, skill and service level as it treats individuals who are not Members; and (ii) engage in no act or omission that discriminates against Members in violation of Applicable Law or Company Policies;

(h) maintain an ongoing internal quality assurance/assessment program that includes, but is not limited to, the credentialing, supervision, monitoring and oversight of its employees and contractors providing services under this Agreement;

(i) cooperate promptly, during and after the term of this Agreement, with reasonable and lawful requests from Company and Payers for information and records related to this Agreement, as well as with all requests from governmental and/or accreditation agencies. Among other things, Service Provider and Network Providers will provide Company and Payers with all information and records necessary for them to properly administer claims and the applicable Plan; resolve Member grievances, complaints and appeals; comply with reporting requirements related to the Affordable Care Act ("ACA") (including, but not limited to, medical loss ratio ("MLR") requirements), perform quality management activities; fulfill data collection and reporting requirements (e.g., HEDIS); and fulfill applicable accreditation (e.g., NCQA) and Federal and state requirements. Service Provider specifically agrees that all records related to this Agreement will be maintained for the longer of ten (10) years or longer period required by Applicable Law;

(j) cooperate with Company in differentiating costs that are medical expenses, costs that are administrative expenses, and costs that are expenses for quality improvement activities, in order for Company to comply with its MLR reporting requirements, and submit such information to Company, electronically, in a format and frequency acceptable to Company;

(k) not provide or accept any kickbacks or payments based on the number or value of referrals in violation of Applicable Law. Unless disclosed in advance to Company and the affected Member, neither Service Provider nor any Network Provider will accept any referral from persons or entities that have a financial interest in them, or make any referrals to persons or entities in which they have a financial interest;

(l) refer Members only to other Participating Providers (including, but not limited to pharmaceutical providers and vendors), unless specifically authorized otherwise by Company and/or permitted by both the applicable Plan and Company Policies;

(m) unless prohibited by Applicable Law or a violation of a specific peer review privilege, notify Company promptly about any of the following of which it knows or reasonably should have known: (i) material litigation brought against Service Provider or a Network Provider that is related to the provision of services to Members and/or that could reasonably have a material impact on the services rendered to Members under this Agreement; (ii) claims against Service Provider or a Network Provider by governmental agencies including, but not limited to, any claims regarding fraud, abuse, self-referral, false claims, or kickbacks; (iii) any loss, suspension or restriction of licensure, accreditation, registration or certification status of Service Provider or a Network Provider related to services provided under this Agreement; (iv) with respect to Service Provider, a change in the ownership or management of Service Provider or material change in services provided by Service Provider;

(n) complete attestation(s), as required by Company, to certify compliance with Applicable Law and the requirements of this Agreement; Service Provider understands and agrees that, in the event of non-compliance, it may be required, by Company, to submit and satisfactorily implement a reasonable corrective action plan(s); and

(o) comply with any additional or modified requirements for care management entities and mental health and behavioral health care providers in connection with the OhioRISE Program specified by ODM, as may be modified from time to time. Such requirements, as may be updated from time to time, will not be considered an amendment or material Policy change under this Agreement.

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2.1.2 Service Provider agrees that it will:

(a) maintain an active, valid Medicaid provider agreement and comply with applicable provider requirements in rule 5160-1-17.2 of the Administrative Code;

(b) participate in initial and ongoing training, coaching, and supports from the Child and Adolescent Behavioral Health Center of Excellence (CABHCOE) to ensure consistency in delivering care coordination;

(c) complete an initial readiness review with the OhioRISE Plan sixty (60) days prior to billing for ICC or MCC;

(d) ensure that all child and family-centered care plans (including initial plans, changes to plans, and transition plans) are submitted to the OhioRISE Plan for review and approval;

(e) exchange electronic, bidirectional data and other information regarding the youth and family receiving ICC and MCC with the OhioRISE Plan;

(f) report the incidents consistent with ODM policies in accordance with rule 5160-44-05 of the Administrative Code;

(g) implement quality improvement activities related to performance consistent with ODM's population health management strategy;

(h) provide all staff with training regarding cultural and trauma-informed care competency within three months of date of hire and annually thereafter;

(i) conduct virtual, in-person or telephonic outreach to the youth's family within one business day of referral to ICC or MCC to explain the service and obtain consent;

(j) have administrative and program staff, in sufficient quantity to meet all the care management entity requirements to achieve the quality, performance, and outcome measures set by ODM;

(k) ensure care coordination staff and supervisors have the experience necessary to manage complex cases and the ability to navigate state and local child serving systems;

(l) have sufficient care coordination staff to meet care coordinator-to-youth ratio requirements prescribed by Applicable Law;

(m) have supervisory personnel to provide coaching and support for ICC and MCC care coordinators, not to exceed the supervisor ratio prescribed by Applicable Law;

(n) provide real-time or on demand clinical and psychiatric consultation for youth engaged in ICC or MCC;

(o) respond to the youth and family twenty-four hours a day;

(p) ensure youth and family choice is incorporated regarding the services and supports they receive and from whom;

(q) ensure that all care coordination services are provided conflict-free, meaning that care coordination functions are separated from service delivery functions. If the CME has both lines of business, the CME must establish firewalls between its care coordination function and its service delivery function; and ensure that care coordinators for a member will not also be related by blood or marriage to the member or any paid caregiver, financially responsible for the member, or empowered to make financial or health related decisions on behalf of the member;

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(r) identify and inform the OhioRISE Plan of unmet needs and barriers to effective care and assist in developing community resources to meet youth and families' needs;

(s) ensure care coordination activities provided are provided via telehealth only when it is the youth or family's choice for service delivery via telehealth;

(t) for youth and family/caregivers who do not respond to the CME's ongoing care coordination efforts, track and report the number of attempts to reach the youth or family/caregiver;

(u) ensure that CME care coordination staff contact the member as identified in the Youth and Family/Caregiver-Centered Plan, but not less frequently than the ODM-approved minimum contact schedule;

(v) for members participating in the OhioRISE Program 1915c Waiver or other home and community-based services waivers, ensure the CME care coordinators submit incidents in accordance with OAC 5160-44-05;

(w) for members with intellectual disabilities and developmental disabilities and receiving care coordination through the Individual Options Waiver (OAC 5160-40), Level One Waiver (OAC 5160-41) and the Self-Empowerment Life Funding Waiver (OAC 5160-41) or Targeted Case Management through local County Boards of Developmental Disabilities, ensure the CME's care coordinators submit incidents for these individuals in accordance with OAC 5123-17-02.

2.2 **Contact and Service Information; Capacity**. Service Provider agrees that it has provided Company with contact and billing information, including, but not limited to, a list of Network Providers (by Individual Site/Network Provider location) and the services provided by the Network Providers at each Individual Site/Network Provider location, that is complete and accurate as of the Effective Date. Such information shall be in an electronic format acceptable to Company and include, without limitation, the following information with respect to the Network Providers and Individual Sites/Network Provider locations: names, tax identification numbers (TINs), office addresses, office hours, telephone number, e-mail address and facsimile numbers, and for physicians and health care professionals, area of practice or specialty. Service Provider will notify Company within ten (10) business days of all changes to any such information. Notwithstanding the foregoing, Service Provider must notify Company at least ninety (90) days in advance, in the event that any Network Provider or Individual Site/Network Provider location is being terminated, opened, acquired, sold, merged and/or closed. Service Provider understands that failure to keep all such contact and service information current and to periodically confirm its accuracy as reasonably requested by Company, will be a material breach of this Agreement. Company's requirements for Service Provider's updating of its information and the actions Company may take if Service Provider fails to confirm its information are outlined in Policies made available to Service Provider. If Company determines at any time, in its sole discretion, that Members' access to Network Providers is unacceptable due to any reduction or change in the number of Network Providers, or any change in the types or geographic mix of Network Providers, Company may request that Service Provider take corrective action acceptable to Company within thirty (30) days. If Service Provider fails to take such corrective action within such thirty (30) day period, Company may terminate this Agreement upon written notice to Service Provider.

2.3 **Compliance with Company Policies**. Service Provider agrees that it will and will require all Network Providers to comply with Company Policies, including, but not limited, those contained in any applicable Provider Manual, as modified by Company from time to time. If a change in a Company Policy would materially and adversely affect Service Provider's administration or rates under this Agreement, Company will send Service Provider at least ninety (90) days advance written notice of the Policy change. Service Provider understands that Policy changes will automatically take effect on the date specified, unless an earlier date is required by Applicable Law. Service Provider is encouraged to contact Company to discuss any questions or concerns with Company Policies or Policy changes.

2.4 **Payment**. Subject to Applicable Law, Service Provider agrees:

(a) to accept the compensation/rates contained in the applicable **Service and Rate Schedule** regardless of where services are provided, as payment in full for Covered Services (including for services that would be Covered Services but for the Member's exhaustion of benefits (e.g., above any annual Plan maximum));

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(b) that it is solely responsible for and will promptly pay all Network Providers for services rendered; that it will require all Network Providers to look solely to Service Provider, and not to Company, Payer or a Member (except for any applicable Plan Member copayments, coinsurance and/or deductibles) for payment; and that failure to require Network Providers to look solely to Services Provider for payment as specified above shall be deemed a material breach of this Agreement. Without limiting any other rights of Company under this Agreement, in the event that Company pays any Network Provider for services provided under this Agreement, it shall be entitled to collect all paid sums from Service Provider and/or to offset any future payments to Service Provider;

(c) to respond within forty-five (45) days to Company or Payer requests for additional information needed by Company to process submitted claims, invoices and/or other payment/compensation requests;

(d) to notify Company of any underpayment, or payment or claim denial dispute, within one hundred and eighty (180) days from date of payment and to follow Company's dispute and appeal Policies for resolution;

(e) to notify Company promptly after becoming aware of any overpayment (e.g., a duplicate payment or payment for services rendered to an individual who was not a Member) and to cooperate with Company for the prompt return of any overpayment. In the event of Service Provider's failure to cooperate with this section, Company shall have the right to offset any overpaid amount against future claims or other payments;

(f) that Company and Payers will not be obligated to pay for claims or other payments not submitted, completed or disputed/appealed as required above, or that are billed in violation of Applicable Law, this Agreement or Company Policies, and that Members may not be billed for any such claims or payments;

(g) in the event that Service Provider or a Network Provider acquires or takes operational responsibility for another Participating Provider (e.g., practice, facility or ancillary provider), the terms and rates of this Agreement will automatically govern with respect to such new provider, unless the Parties reach mutual agreement on other rates.

2.5 **Member Billing**. Service Provider agrees that it will and will require Network Providers to comply with the following: (a) Members will not be billed or charged, by Service Provider or by any Network Provider, any amount for Covered Services, except for applicable copayments, coinsurance and deductible amounts; (b) If services are not reimbursed because of Service Provider's or a Network Provider's failure to comply with its obligations under this Agreement (e.g., for late submission of claims), Members may not be billed for those services; and (c) A Member may be billed for services that are not Covered Services under the Member's Plan (including for services that are not considered "medically necessary" under a Plan) only if the Member has been informed by Service Provider or the applicable Network Provider that those services are not covered and has agreed, in advance, to pay for the services. This section will survive the termination of this Agreement.

2.6 **Utilization Management**. Service Provider agrees that it and/or Network Providers shall be subject to utilization management (including, as applicable, prospective, concurrent and retrospective review) in accordance with Company Policies and that payment may be adjusted or denied for the inefficient delivery of services.

2.7 **Precertification and Referrals**. Service Provider agrees that it will and will require all Network Providers to comply with any applicable precertification, site of care and/or referral requirements under the Member's Plan and Company Policies. For the purpose of applicable pre-service testing, if any, Service Provider agrees to require Network Providers to directly provide testing or accept outside test results and examination, provided such tests and examinations are: (a) performed by a state licensed laboratory for laboratory tests, and a licensed physician for such other tests and examinations; and (b) performed within a time reasonably proximate to the delivery of services. For those Members who require services under a specialty program, Service Provider agrees that it will and will require Network Providers to work with Company in transferring the Member's care to a specialty program provider.

2.8 **Audit**. Without limiting Company's additional rights under any Delegated Services Addendum or Delegation Agreement, Service Provider agrees, on behalf of itself and its Network Providers and other subcontractors, that Company, Company's designated agent(s), governmental authorities having jurisdiction, and any applicable accrediting organizations may audit (on-site or otherwise), upon at least ten (10) calendar days prior written notice (or upon shorter notice in the event that Company determines a shorter period is necessary to ensure Company's compliance with Applicable Law), any and all documents and materials related to services rendered under this Agreement, during the term of this Agreement and for a period of three (3) years thereafter.

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2.9 **Off-Shoring**. Service Provider shall not and shall prohibit its Network Providers and other subcontractors from using any individual or entity to perform any services for Plans (including, without limitation, the receipt, processing, transferring, handling, storing, maintaining, creating, or accessing of PHI or PII for any period of time for any reason) if the individual or entity is physically located outside of one of the forty-eight (48) contiguous states of the United States ("Offshore Entity"), unless: (a) Company, in its sole discretion and judgment, agrees in advance and in writing to the use of such Offshore Entity; and (b) such off-shoring of services is permitted by Applicable Law. In the event that Company provides Service Provider or a Network Provider with prior written approval to use an Offshore Entity to perform any services for Plans, Service Provider shall take all steps necessary to ensure that Offshore Entity complies with the requirements of this Agreement and Applicable Law. Service Provider further agrees that Company has the right to audit any Offshore Entity prior to the Offshore Entity's provision of services for Plans.

2.10 **Background Investigation**. Service Provider agrees that before deploying Network Providers or any other personnel to provide services under this Agreement, Service Provider will conduct a background investigation through a consumer reporting agency or other reputable third party background investigation agency. Service Provider agrees that it will not deploy any person to provide services whose background investigation reveals that such person has been convicted of either (a) any criminal felony; or (b) any crime involving dishonesty or a breach of trust; or (c) any offense under 18 U.S.C. Section 1033 of the Violent Crime Control and Law Enforcement Act of 1994, which section is captioned "Crimes by or Affecting Persons Engaged in the Business of Insurance Whose Activities Affect Interstate Commerce." The investigation shall also include a check of the National Security/Terrorist Watch List, Office of Foreign Asset Control, Terrorism Watch List, Denied Persons List, Interpol Most Wanted List, Office of Inspector General List, General Services Administration Excluded Parties List System, and federal, state, and local sex offender registries, and an interview/evaluation on competence, empathy, communication skills, and client-focused care. Service Provider agrees that Company may conduct a background investigation on Service Provider.

2.11 **Ownership of Work Product/Infringement**. Unless otherwise agreed to in writing by authorized representatives of the Parties, all original materials and Work Product produced by Service Provider and/or Network Providers as part of the services provided by it hereunder, and all right, title and interest in such materials, shall belong exclusively to Company. By execution of this Agreement, Service Provider hereby agrees to assign and irrevocably does assign any and all title and interests in such materials and Work Product to Company, including all rights of every kind in the materials for the entire duration of the intellectual property right. No rights are reserved to Service Provider and/or Network Providers.

Service Provider warrants that the services do not infringe any patent, copyright, trademark or other third party intellectual property right. Service Provider agrees to defend at its own expense and to pay all costs and damages awarded in any suit against Company, its agents and/or customers or Members alleging such infringement. Service Provider agrees that upon receiving notice of such action, it shall, at its expense and option, either (a) procure for Company the right to continue use; (b) replace or modify the services so as to be non-infringing; or (c) discontinue usage and refund to Company any compensation paid to Service Provider related to the infringing services.

2.12 **Non-Recruitment and Non-Hire**. Neither Company nor Service Provider (including without limitation any Network Provider) shall, without the other Party's prior written consent, actively recruit and/or employ any individual who is regularly performing work under this Agreement for the other Party during the term of the Agreement and for a period of one (1) year following the cessation of such individual's work under the Agreement.

2.13 **Tier 3 Intensive Care Coordination (ICC)**. If delivering ICC, Service Provider shall:

(a) Provide structured service planning and care coordination through High-Fidelity Wraparound as established by the national wraparound initiative, found at https://nwi.pdx.edu (October 1, 2021), including:

(i) An initial face-to-face contact will be offered within two (2) calendar days of referral for ICC; and

(ii) An initial comprehensive assessment within fourteen (14) calendar days of the youth's referral to ICC that includes:

(1) Information from a new Child and Adolescent Needs and Strengths (CANS) assessment or existing CANS assessment that was completed within the ninety (90) calendar days prior to the comprehensive assessment; and

(2) Other tools as determined necessary that inform and result in the development of the child and family-centered care plan;

(iii) A completed Ohio comprehensive CANS assessment within thirty (30) calendar days of referral to ICC;

(iv) Updating the CANS assessment at a minimum of every ninety (90) calendar days or whenever there is a significant change in the youth's needs or circumstances;

(v) Convening and facilitating the child and family team within thirty (30) calendar days of referral for ICC that will:

(1) Develop and implement the initial child and family-centered care plan within the thirty (30) calendar day period; and

(2) Review the child and family-centered care plan every thirty (30) calendar days, and whenever there is a significant change in the youth's needs or circumstances.

(vi) Developing a crisis safety plan, within fourteen (14) calendar days of referral for ICC, for incorporation into the child and family-centered care plan;

(vii) Monitoring the child and family-centered care plan to ensure that services are delivered in accordance with the plan;

(viii) Performing referrals and linkages to appropriate services and supports, including natural supports, along the continuum of care;

(ix) Facilitating discharge planning activities for youth admitted to a psychiatric residential treatment facility or an inpatient behavioral health facility; and

(x) Facilitating transition activities for youth transitioning amongst and between all facility and community-based settings.

(b) Have documentation of annual fidelity review, monitoring, and adherence to High-Fidelity Wraparound by an independent validation entity recognized by ODM. The fidelity review will assess for consistent use of High-Fidelity Wraparound standards established by the national wraparound initiative.

(c) Submit the child and family-centered care plan to the OhioRISE Plan within one business day of completion of the child and family-centered care plan.

2.14 **Tier 2 Moderate Care Coordination (MCC)**. If delivering MCC, Service Provider shall:

(a) Provide structured service planning and care coordination based on wraparound principles, as established by the national wraparound initiative, found at https://nwi.pdx.edu (October 1, 2021), including;

(i) An initial face-to-face contact will be offered within seven (7) calendar days of referral for MCC; and

(ii) An initial comprehensive assessment within fourteen (14) calendar days of the youth's referral to MCC that includes:

(1) Information from a new CANS assessment or existing CANS assessment completed within the ninety (90) days prior to the comprehensive assessment; and

(2) Other tools as determined necessary that inform and result in the development of the child and family-centered care plan.

(iii) A completed Ohio comprehensive CANS assessment within thirty (30) calendar days of referral to MCC;

(iv) Updating the CANS assessment at a minimum of every ninety (90) calendar days or whenever there is a significant change in the youth's behavioral health needs or circumstances;

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(v) Convening and facilitating the child and family team within thirty (30) calendar days of referral for MCC that will:

(1) Develop and implement the initial child and family-centered care plan within the thirty (30) calendar day period; and
(2) Review the child and family-centered care plan every sixty (60) calendar days, and whenever there is a significant change in the youth's needs or circumstances.

(vi) Developing a crisis safety plan, within fourteen (14) calendar days of referral for MCC, for incorporation into the child and family-centered plan;

(vii) Monitoring the child and family-centered care plan to ensure that services are delivered in accordance with the plan;

(viii) Performing referrals and linkages to appropriate services and supports, including natural supports, along the continuum of care;

(ix) Facilitating discharge planning activities for youth admitted to a psychiatric residential treatment facility or an inpatient behavioral health facility; and

(x) Facilitating transition activities for youth transitioning between facility and community-based settings.

(b) Have documentation of annual fidelity review, monitoring, and adherence to MCC by an independent validation entity recognized by ODM. The fidelity review will assess for consistent application of system of care principles, adherence to the MCC planning process and service components.

(c) Submit the child and family-centered care plan to the OhioRISE Plan within one (1) business day of completion of the child and family-centered care plan.

2.15 **Transition of Care**.

If youth and family/caregiver needs to change care coordination tiers due to changing needs or a preference for a lower care coordination tier, Service Provider shall make the request to the OhioRISE Plan, which shall include a CANS assessment updated within ninety (90) days.

When a youth is discharging from a facility level of care or residential intervention, Service Provider shall designate care coordination staff to communicate with the discharging facility and participate in discharge planning. With support from the OhioRISE Plan, Service Provider shall obtain a copy of the discharge/transition plan, arrange, and confirm services are authorized, scheduled, and delivered in accordance with the transition/discharge plan. As part of the transition and discharge planning, Service Provider shall initiate a Youth and Family Team (YFT) to share the plan with the youth's facility care team and follow up post discharge to ensure services are provided.

When youth and/or families/caregivers move from one Managed Care Organization (MCO) to another, Service Provider shall have processes in place for helping the youth and family/caregiver through this transition. These processes shall include at a minimum:

(a) Ensuring the name and contact information for any assigned MCO Care Manager Plus or Care Guide Plus is available to the youth and family/caregiver;
(b) Reaching out to any Care Manager Plus or Care Guide Plus at the new MCO within a reasonable timeframe as specified by ODM; and
(c) Supporting the family/caregiver to contact the new MCO and appropriate care coordination resources as needed as a part of the MCO-to-MCO transition.

2.16 **Staffing and Supervision**.

All care coordination staff employed/contracted by Service Provider, including without limitation Network Providers, shall be skilled at engaging and working with youth with significant behavioral health needs and their families/caregivers. These staff/Network Providers shall also have a thorough understanding of local communities, be

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skilled at developing working relationships with community agencies, be able to identify potential community supports for development to assist families/caregivers and work collaboratively with the youth and family/caregiver teams. Care coordination staff and Network Providers employed/contracted by Service Provider shall be in Ohio and preferably live in the Service Provider assigned Catchment Area. The OhioRISE Care Coordination Rule 5160-59-03.2 requires Service Provider to:

(a) Ensure staff and supervisors have the experience necessary to manage complex cases and the ability to navigate state and local child serving systems;

(b) Ensure care coordination is provided by the Service Provider within the youth and family/caregiver's community;
(c) Have the capacity to meet care coordinator-to-youth and family/caregiver ratio requirements of 1:10 for ICC and 1:25 for MCC;
(d) Have the capacity to offer adequate supervision and coaching to support care coordinators, not to exceed the supervisor ratio of 1:8;
(e) Have the capacity to provide real-time or on demand clinical and psychiatric consultation for youth engaged in care coordination;
(f) Have the ability to respond to member needs twenty-four (24) hours a day;
(g) Ensure youth and families/caregivers have a voice and choice of assigned care coordinator. Care coordination staff/Network Providers shall not be related by blood or marriage to the youth or family/caregiver, or any paid caregiver, financially responsible for the member, or empowered to make financial or health related decision on behalf of a youth and family/caregiver; and
(h) Have sufficient administrative and program staff to meet all the Service Provider requirements to achieve the quality, performance, and outcome measures set by ODM.

2.17 **Community Resource Development**. In order to develop needed services and support in the community, Service Provider shall:

(a) Identify formal and informal resources in Service Provider's Catchment Area, initially and on an ongoing basis, paying particular attention to the availability of culturally responsive resources for youth and family/caregivers of the various racial and ethnic communities in the area. These shall include, but are not limited to, affiliations with informal or natural helping networks such as neighborhood and civic associations, faith-based organizations, and recreational programs.

(b) Refer identified service providers who are not currently contracted with Company for the Ohio Rise Program to Company either for contracting or to develop a Single Case Agreement (SGA).

(c) Capture information on resources in a useable format such as a database and make it accessible to Care Coordinators, Youth and Family/Caregiver Teams (YFT) and youth and family/caregivers.
(d) Collect and use feedback on resources from youth, family/caregivers and YFT members.
(e) Determine the need for additional capacity and/or new resources. (Service Provider is responsible for ensuring that youth and caregivers have a choice between at least two providers of a needed Medicaid covered service). Work with the OhioRISE Plan, providers and community leaders to address those gaps.
(f) Prepare an annual resource development plan to be shared with the OhioRISE Plan and ODM.
(g) Establish policies and procedures to manage direct referrals to Service Provider's parent and affiliated organizations, if any, to be submitted to the OhioRISE Plan for approval, including disclosure of all direct and indirect owners. The OhioRISE Plan will monitor Service Provider's implementation of its policies and procedures as well as the number of referrals to Service Provider's parent organization to ensure that the referrals comply with any rules or requirements regarding the number of referrals received by the parent organization.

2.18 **Collaboration with Child-Serving State Agencies and Schools**.

Delivery of High-fidelity Wraparound requires care coordinators and Youth and Family/Caregiver Team (YFTs) members to establish strong partnerships and collaborative working relationships with local government and community-based agencies. Service Provider shall leverage established local systems of care and stakeholder partnerships and shall address

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how Service Provider will collaborate with local child-serving systems to improve care coordination and reduce the burden on youth and families/caregivers.

(a) Collaboration with Child Welfare - Collaboration with service and custodial agencies such as the Ohio Department of Job and Family Services is essential to achieve the goals of the OhioRISE Program. Service Provider shall work with local Ohio Department of Job & Family Services (ODJFS) offices both in the course of work on behalf of individual youth and their families/caregivers and also through ongoing communication between Service Provider and ODJFS managers. Service Provider, in collaboration with youth and family/caregivers, shall make every effort to include ODJFS staff in Youth and Family/Caregiver Teams.

(i) Prior to inviting ODJFS staff to join a youth's YFT, Service Provider shall ask the parent or legal guardian, as appropriate, to sign a release to allow the care coordinator to contact relevant ODJFS staff, explain the role of the Service Provider in the OhioRISE Program and ICC or MCC process, ask for a copy of the most recent service plan and invite them to join the YFT.

(ii) Facilitate participation of ODJFS staff in YFT meetings. With appropriate consent, Service Provider staff shall provide up-to-date Youth and Family/Caregiver-Centered Plans to ODJFS staff.

(iii) If the County Public Children's Services Agency (PCSA) places a youth who is receiving ICC in a foster care setting, Service Provider shall work with the caregiver and PCSA to schedule a team meeting for care coordination and planning. If the caregiver is located outside of the Service Provider Catchment Area, Service Provider may consider working with PCSA and the YFT to transfer ICC services to the youth's closest care management service provider. Any transition of care shall include the youth and parent/caregiver, the PCSA caseworker(s) current and new, and the existing YFT.

(b) Collaboration with Other Providers of Behavioral Health Services.

(i) Service Provider is responsible for assisting the OhioRISE Program youth in accessing medically necessary covered services. As part of this role, behavioral health service providers shall be considered YFT members and regularly invited to attend YFT meetings.

(ii) In preparation of adding a new member to the YFT, the care coordinator shall ask the parent/caregiver to provide a release of information to contact these providers after the youth is enrolled to explain the role of Service Provider and to request a copy of the most recent treatment plans.

(iii) Partnering with behavioral health service providers may need to be creative and understanding of providers' time constraints. For example, engagement in the YFT may need to occur through email, phone calls, or other communication methods. This flexibility will ensure the behavioral health service provider is looped into the YFT and has access to the Youth and Family/Caregiver-Centered Plan.

(c) Collaboration with Primary Care.

(i) Service Provider shall engage the primary care provider as part of the YFT. The care coordinator shall ask the caregiver for a release of information authorizing the exchange of service information between the primary care provider (PCP), Service Provider, and any other relevant service provider, as appropriate.

(ii) The Service Provider care coordinator shall invite the PCP to participate in all YFT meetings. Service Provider shall offer coordination through email, phone calls, or other communication methods. Any identified medical needs should be documented in the Youth and Family/Caregiver-Centered Plan and the youth's PCP should be apprised of the youth's progress.

(d) Collaboration with County Departments of Developmental Disabilities.

Service Provider shall establish relationships with the County Board of Developmental Disabilities to ensure both parties are informed of programming and services available, eligibility standards and processes for enrollment.

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For OhioRISE Program youth with intellectual disabilities and developmental disabilities and receiving care coordination through ODM Waiver services, including participating in home and community-based services waivers, Service Provider care coordinators shall collaborate with the local County Boards of Developmental Disabilities through inclusion in YFT meetings and sharing of the Youth and Family/Caregiver-Centered Plan.

(i) Prior to inviting County Board of Developmental Disabilities staff to join a youth's YFT, Service Provider care coordinators shall ask the parent/caregiver to sign a release to allow the care coordinator to contact relevant County Board of Developmental Disabilities staff, explain the role of the Service Provider in the OhioRISE Program and ICC or MCC process, ask for a copy of the most recent service plan and invite them to join the YFT.

(ii) Service Provider shall facilitate participation through video or phone links when necessary. With appropriate consent, Service Provider staff shall provide up-to-date Youth and Family/Caregiver-Centered Plans to County Board of Developmental Disabilities staff.

(e) Collaboration with Local Justice/Court Systems.

Service Provider shall establish relationships with local Courts and criminal justice agencies to ensure such entities are informed of the OhioRISE Program, the services available, eligibility standards and processes for enrollment.

The High-Fidelity Wraparound care planning process shall include an assessment of and planning regarding a youth's involvement in the juvenile or adult justice systems, if any. Whether there is specific involvement from court staff or probation or juvenile justice staff in the youth's YFT will depend on the status of the legal proceedings and advice of the youth's and family/caregiver's legal counsel.

Service Provider shall work with the youth and family/caregiver and YFT to identify natural supports in effort to prevent reentry into the juvenile justice system or entry into the adult criminal justice system. Service Provider shall receive support though the OhioRISE Plan's regional liaisons who work at the intersection of the legal, justice, health care, and child welfare systems and provide technical assistance for Service Provider and stakeholders.

(f) Collaboration with Schools.

Each OhioRISE Program youth shall have a Youth and Family/Caregiver-Centered Plan based on regular CANS assessments. Youth and Family/Caregiver-Centered Plans address the youth's needs across multiple life domains including living environment, basic needs, safety, social, emotional, educational, spiritual, and cultural needs. Interventions are planned to achieve specific goals. To ensure a youth's needs are met in the educational setting, Service Provider shall engage school systems in the Youth and Family/Caregiver-Centered Planning process. Service Provider shall ask the parent/caregiver to provide a release of information authorizing the exchange of service information, including any Ohio Individualized Education Plan (IEP) pursuant to the The Individuals with Disabilities Education Act (IDEA) 2004, between the care coordination provider and school personnel working with the youth and family/caregiver. A variety of methods may need to be used to engage school staff, including ample advance notice of YFT meetings, use of phone and teleconference technology for meetings as well as regular email communication.

(g) Collaboration with Family and Children First Councils.

Service Provider shall collaborate with the local Children and Family First Council (FCFC) and develop strategies to establish new relationships or expand current collaborations with the local FCFC.

2.19 **<u>Conflict Free Service Referral</u>**. If Service Provider is part of a larger organization that provides services, including inpatient acute, psychiatric residential treatment facility (PRTF), mobile response and stabilization service (MRSS), outpatient services, and CANS assessments to determine OhioRISE Program eligibility, Service Provider shall ensure conflict free referral to services within its own organization. Service Provider shall establish policies and procedures to limit

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direct referrals to its parent organization and be submitted to the OhioRISE Plan for approval. Service Provider's referrals to Service Provider's parent organization or affiliated organizations must not exceed applicable or reasonable limits total number of referrals received by Service Provider's parent organization and such requirement must be contained in and implemented through Service Provider's policies and procedures. The OhioRISE Plan may monitor Service Provider's policies and procedures and referrals for compliance with this Section.

2.20 **Training and Quality Oversight and Improvement**.

(a) Training. Service Provider shall participate in ongoing training, coaching, and supports from CABHCOE on High-Fidelity Wraparound and the Child and Adolescent Needs Assessment (CANS) tool. Service Provider shall ensure all staff, including without limitation Network Providers, complete training regarding culturally responsive and trauma-informed care according to standards set by ODM, within twelve (12) months of program start and annually thereafter. Service Provider staff shall be trained to educate youth and families/caregivers on the availability, convenience, difference in modalities, and pros and cons of telehealth services so youth and families/caregivers can make informed choices about telehealth.

(b) Quality Oversight and Improvement. Service Provider will partner with the OhioRise Plan and CABHCOE to develop a OhioRISE Quality Framework to measure performance, identify best practices and develop, implement and measure quality improvement activities. The scope of the OhioRISE Quality Framework shall include, at a minimum:

1. Analyzing membership characteristics to ensure the OhioRISE Program is enrolling and retaining youth and families/caregivers from all communities in the Service Provider's Catchment Area;
2. Monitoring engagement activities and time frames with youth and families/caregivers;
3. Monitoring adherence to the OhioRISE Program and CME Rules 5160-59-01 – 5160-59-03;
4. Ongoing measurement of fidelity to the National Wraparound Initiative Standards of Care; and
5. Measurement of Service Provider's performance on ODM's Health Children Quality measures.

2.21 **Electronic Medical Record and Data Reporting Requirements**. Service Provider shall be responsible for reporting data to and sharing data with the OhioRISE Plan in alignment with the OhioRISE Plan provider agreement with ODM.

2.22 **Implementation Support and Readiness Review**. Service Provider shall have administrative and program staff in sufficient quantity to meet all CME requirements to achieve the quality, performance, and outcome measures set by ODM and the OhioRISE Plan.

3.0 COMPANY OBLIGATIONS.

3.1 **General Obligations**. Company agrees that:

(a) unless an exception is stated in the applicable exhibit, Company or Payers will: (i) provide Members with a means to identify themselves to Network Providers; (ii) provide Service Provider and/or the applicable Network Provider with an explanation of provider payments, a general description of products and a listing of Participating Providers; (iii) provide Service Provider and/or the applicable Network Provider with a means to check Member eligibility; and (iv) include Service Provider and/or Network Providers in the Participating Provider directory(ies) for the applicable Plans;

(b) it, through its applicable Affiliate(s), will be appropriately licensed, where required, to offer, issue and/or administer Plans in the geographic areas covered by this Agreement;

(c) it is, and will remain throughout the term of this Agreement, in material compliance with Applicable Law related to its performance of its obligations under this Agreement;

(d) it will notify Service Provider of periodic updates to its Policies as required by this Agreement and make current Policies available to Service Provider or Network Providers electronically or through other commonly accepted media.

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3.2 **Compensation/Payment**. Subject to Applicable Law, the terms of each applicable **Product Addendum**, and Company's payment and review Policies (e.g., prepayment review of certain claims), and except for applicable Member copayments, coinsurance and deductibles, Company agrees when it is the Payer, to pay Provider for Covered Services rendered to Members; and when it is not the Payer, to notify the Payer to forward payment to Provider for Covered Services; in each case, within forty-five (45) days of receipt of a clean, complete, undisputed electronic claim**.**

3.3 **Implementation Support and Readiness**. The OhioRISE Plan and Service Provider shall assess operational and capacity readiness sixty (60) to ninety (90) days in advance of the Effective Date of this Agreement to ensure the Service Provider is well supported to begin providing the services described in this Agreement. The OhioRISE Plan readiness assessment will focus on Service Provider's staffing, training, system readiness and data exchange capabilities. This collaborative process will work to support Service Provider through technical assistance to resolve issues and potential risks prior to the Effective Date of this Agreement. Ongoing technical assistance and support will be provided for Service Provider through assigned OhioRISE Plan liaisons. The liaison will assist with any continued risks and areas of concern.

(a) Training. Company will partner with CABHCOE to provide staff training to Service Provider's staff on High Fidelity Wraparound and the CANS tool. The OhioRISE Plan, Service Provider and CABHCOE shall collaboratively identify other training needs on an ongoing schedule. Other training opportunities will be available through Aetna Better Health of Ohio's SHINE University.

(b) Quality. Data collection, monitoring, analysis, and shared learning is essential to the successful implementation of the OhioRISE Program. The OhioRISE Plan and the CABHCOE shall collaborate with Service Provider to support quality improvement capacity building and shared learning through the implementation process. The OhioRISE Program shall be an environment for Service Provider and other CMEs to learn from each other to improve their care coordination processes and health outcomes.

4.0 NETWORK PARTICIPATION.

Service Provider agrees that it and Network Providers (in all Individual Sites and Network Provider locations) will participate in the Product Categories specified on the Signature Page to this Agreement**.** Company has the right, upon ninety (90) days written notice to Provider, to:

(a) add Product Categories (e.g., Medicare or a new Product Category not existing as of the Effective Date); and
(b) add types of Plans (e.g., PPO, HMO) and/or specialty programs (e.g., disease management or women's health) in any Product Category;

Company will notify Service Provider of the rates that will apply for any addition and will, as necessary, send Service Provider a new or revised **Product Addendum** and **Service and Rate Schedule**.

Service Provider can decline any addition by notifying Company in writing, within thirty (30) days of receiving Company's notice. A variation of an existing Product Category, Plan type or specialty program at existing terms and rates will not be considered "an addition" under this section.

Company is not required to designate, include, or continue to include Service Provider or any specific Network Provider(s) or any specific Individual Site/Network Provider location(s) as a preferred provider or Participating Provider in any specific Product Category, Plan (or Plan variation), product, specialty program or geographic area. Company may operate networks in which Service Provider and/or specific Network Providers are not included, whether for specific Payers/customers or otherwise. In certain situations, a Network Provider may provide services to a Member of a Plan or Product Category in which the Network Provider does not participate (e.g., a Member traveling out of area, emergency services). In those situations, Company may apply rates and terms (e.g., no balance billing) under this Agreement for Covered Services provided to those Members. Not all Product Categories and Plan types are available in all geographic locations.

5.0 CONFIDENTIALITY.

Company and Service Provider agree that medical records do not belong to Company. Company and Service Provider agree that the information contained in claims and/or requests for payment submitted under this Agreement belongs to Company and/or the applicable Payer and may be used by Company and/or the applicable Payer for quality management,

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plan administration and other lawful purposes. Company and Service Provider will, and Service Provider will require Network Providers to, maintain and use confidential Member information and records in accordance with Applicable Law. Each Party agrees that the confidential and proprietary information of the other Party is the exclusive property of that other Party and, unless publicly available, each Party agrees to keep the confidential and proprietary information of the other Party strictly confidential and not to disclose it to any third party without the other Party's consent, except: (a) as required by Applicable Law; (b) to governmental authorities having jurisdiction; (c) in the case of Company's disclosure, to Members, Payers, prospective or current customers, or consultants or vendors under contract with Company; and (d) in the case of Service Provider's disclosure, to Network Providers, so that Network Providers can advise Members of potential service options and costs associated with their care. Service Provider and Network Providers will keep the rates and the development of rates and other terms of this Agreement confidential; provided, however, that nothing herein shall be deemed to prohibit Service Provider, Network Providers, Company and/or Payers from disclosing rates and/or other information as required by Applicable Law (e.g., to promote transparency in pricing and quality information). Network Providers are encouraged to discuss Company's provider payment methodology with Members, including descriptions of the methodology under which they are paid. In addition, Service Provider and Network Providers are encouraged to communicate with Members about their service options, regardless of benefit coverage limitations. This section will survive the termination of this Agreement.

6.0 ADDITIONAL TERMINATION RIGHTS AND OBLIGATIONS.

6.1 **Termination of Individual Network Providers**. Company may terminate the participation of one or more Network Providers, Individual Sites or Network Provider locations by providing Service Provider with at least ninety (90) days' written notice prior to the date of termination.

6.2 **Termination for Breach**. This Agreement may be terminated at any time by either Party upon at least sixty (60) days prior written notice of such termination to the other Party, upon such other Party's material breach of its obligations under this Agreement, unless such material breach is cured within sixty (60) days of the notice of termination. In addition, Company may terminate this Agreement due to significant or repeated Member or ODM dissatisfaction with Service Provider or Network Providers, upon at least sixty (60) days prior written notice of such termination by Company to Service Provider, unless Service Provider and, as applicable, Network Providers, implement a corrective action plan which, as determined by Company, is reasonably likely, in a prompt manner, to resolve any such significant or repeated dissatisfaction.

6.3 **Immediate Termination or Suspension**. Company may terminate or suspend this Agreement with respect to Service Provider or any Network Provider(s) (including, but not limited to, any Individual Site or Network Provider location), with written notice to Service Provider, due to: (a) Service Provider's or the applicable Network Provider's failure to continue to maintain applicable licenses, accreditations and/or registrations and/or meet the requirements of the OhioRISE Program or other applicable Participation Criteria; (b) bankruptcy or receivership or an assignment by Service Provider or the applicable Network Provider for the benefit of creditors; (c) Service Provider's or the applicable Network Provider's indictment, arrest or conviction of a felony or other crime related to fraud or the practice of medicine/provision of health care or health care-related services; (d) the exclusion, debarment or suspension of Service Provider or the applicable Network Provider from participation in any governmental sponsored program, including, but not limited to, Medicare or Medicaid; (e) change of control of Service Provider or the applicable Network Provider to an entity not acceptable to Company; (f) any false statement or material omission of Service Provider or a Network Provider (e.g., in a network participation application) with respect to this Agreement; or (g) a determination by Company that continued participation in provider networks could reasonably result in harm to Members. Service Provider will provide prompt notice to Company of any of the events described in (a)-(f) above. Service Provider may terminate this Agreement, with written notice to Company due to: (x) Company's failure to continue to maintain the licensure and/or other authorizations required for it to meet its obligations under this Agreement; or (y) Company's bankruptcy or receivership, or an assignment by Company for the benefit of creditors.

6.4 **Obligations Following Termination**. Upon termination of this Agreement for any reason, Service Provider agrees to provide services, at Company's discretion in any situation required by Applicable Law (e.g., registered inpatient at a hospital). In addition, upon notice of termination of this Agreement or of participation in a Plan, Service Provider agrees to facilitate and cooperate with the transfer of care for any Members then receiving services under this Agreement to another Participating Provider. The applicable **Service and Rate Schedule** will apply to all services provided under this section. Company may provide advance notice of the termination to Members.

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6.5 **Obligations During Dispute Resolution Procedures**. In the event of any dispute between the Parties in which a party has provided notice of termination for breach under Section 6.2 above, and the dispute is required to be resolved or is submitted for resolution under Section 8.0 below, the termination of this Agreement shall cease and the Parties shall continue to perform under the terms of this Agreement until the final resolution of the dispute.

7.0 RELATIONSHIP OF THE PARTIES.

7.1 **Independent Contractor Status/Relationship**. The Parties are independent contractors, and not employees, agents or representatives of each other. Each Party will be solely liable for its own activities and those of its employees and other agents, and neither Company nor Service Provider will be liable in any way for the activities of the other Party or the other Party's employees or other agents. Service Provider acknowledges that all Member care and related decisions are the responsibility of Service Provider and/or Network Providers, as the case may be, and that Policies do not dictate or control Service Provider's and/or Network Providers' clinical decisions with respect to the care of Members. Service Provider agrees to indemnify and hold harmless Company from any and all third-party claims, liabilities and causes of action (including, but not limited to, reasonable attorneys' fees) arising out of Service Provider's and/or Network Providers' provision of care/services to Members. Company agrees to indemnify and hold harmless Service Provider from any and all third-party claims, liabilities and causes of action (including, but not limited to, reasonable attorneys' fees) arising out of the Company's administration of Plans. This provision will survive the termination of this Agreement.

7.2 **Use of Name**. Service Provider agrees that its and Network Provider's names and other identifying and descriptive material can be used in provider directories and in other materials and marketing literature of Company and Payers, including, but not limited to, in customer bids, requests for proposals, state license applications and/or other submissions. Service Provider will not and will not permit any Network Provider to use Company's or its Affiliates' or a Payer's names, logos, trademarks or service marks without Company's and/or the applicable Payer's prior written consent; provided that Service Provider and/or Network Providers, as applicable, shall be able to state that they are Participating Providers with Company or its Affiliates without prior written consent from Company. Neither Service Provider nor any Network Provider may issue a press release or other public statement regarding this Agreement without Company's prior written consent. Service Provider agrees to include Company on the mailing list for its communications to its Network Providers.

7.3 **Interference with Contractual Relations**. Service Provider will not engage in and will prohibit Network Providers from engaging in activities that would cause Company to lose existing or potential Members, including but not limited to, advising Company customers, Payers or other entities currently under contract with Company to cancel, or not renew their contracts. Except as required under this Agreement or by a governmental authority or court of competent jurisdiction, Service Provider will not use or disclose and will prohibit Network Providers from using and disclosing membership lists acquired during the term of this Agreement including, but not limited to, for the purpose of soliciting individuals who were or are Members or otherwise to compete with Company. Nothing in this section is intended or will be deemed to restrict: (a) any communication between a Network Provider and a Member, or a party designated by a Member, that is determined by the Network Provider to be necessary or appropriate for the diagnosis and/or care of the Member; or (b) notification of participation status with other insurers or plans. This section will survive the termination of this Agreement for a period of one (1) year following termination.

8.0 DISPUTE RESOLUTION.

8.1 **Dispute Resolution**. Company will provide an internal mechanism under which Service Provider can raise issues, concerns, controversies or claims regarding the obligations of the Parties under this Agreement. Service Provider will and will require Network Providers to exhaust Company's internal mechanisms before instituting any arbitration or other permitted legal proceeding. The Parties agree that any discussions and negotiations held during this process will be treated as settlement negotiations and will be inadmissible into evidence in any court proceeding, except to prove the existence of a binding settlement agreement.

8.2 **Arbitration**. Any controversy or claim arising out of or relating to this Agreement, including breach, termination, or validity of the Agreement, except for injunctive relief or any other form of equitable relief, will be settled by confidential, binding arbitration, in accordance with the Commercial Rules of the American Arbitration Association. **COMPANY AND SERVICE PROVIDER AGREE THAT, BY AGREEING TO THIS ARBITRATION PROVISION, EACH MAY BRING CLAIMS AGAINST THE OTHER ONLY IN THEIR INDIVIDUAL CAPACITY, AND NOT AS**

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A PLAINTIFF OR CLASS MEMBER IN ANY PURPORTED CLASS OR REPRESENTATIVE PROCEEDING FOR ANY DISPUTE ARISING OUT OF OR RELATING TO THIS AGREEMENT. The arbitrator may award only compensatory damages for breach of contract, and is not empowered to award punitive, exemplary or extra-contractual damages. Where a Party's claim is for greater than Ten Million Dollars ($10,000,000), a panel of three (3) arbitrators (one chosen by each Party and the third to be a former Federal district court judge agreed upon by the Parties) will preside over the matter, unless the Parties agree otherwise. If a Party's claim is for less than Ten Million Dollars ($10,000,000), a single (1) arbitrator will preside over the matter, unless the Parties agree otherwise. The arbitrator(s) are bound by the terms of this arbitration provision. In the event a Party believes there is a clear error of law and within thirty (30) days of receipt of an award of $250,000 or more (which shall not be binding if an appeal is taken), a Party may notify the AAA of its intention to appeal the award to a second arbitrator (the "Appeal Arbitrator"), designated in the same manner as the original, except that the Appeal Arbitrator(s) must have at least twenty (20) years' experience in the active practice of law or as a judge. The award, as confirmed, modified or replaced by the Appeal Arbitrator, shall be final and binding, and judgment thereon may be entered by any court having jurisdiction thereof. No other arbitration appeals may be made. Except as may be required by law or to the extent necessary in connection with a judicial challenge, permitted appeal, or enforcement of an award, neither a Party nor an arbitrator may disclose the existence, content, record, status or results of dispute resolution discussions or an arbitration. Any information, document, or record (in whatever form preserved) referring to, discussing, or otherwise related to dispute resolution discussions or arbitration, or reflecting the existence, content, record, status, or results of dispute resolution discussions or arbitration is confidential. The Parties are entitled to take discovery consistent with the Federal Rules of Civil Procedure (including, but not limited to, document requests, expert witness reports, interrogatories, requests for admission and depositions). This section will survive the termination of this Agreement.

9.0 MISCELLANEOUS.

9.1 **Entire Agreement**. This Agreement and any exhibits, addenda, schedules or appendices to it constitutes the entire understanding of the Parties and supersedes any prior agreements related to the subject matter of this Agreement. If there is a conflict between the **General Terms and Conditions** and an Exhibit (e.g., a **Product Addendum**) the terms of the exhibit will apply to the applicable category or service. If there is a conflict between an applicable **state-specific or Federal Compliance Addendum** and any other part of the Agreement, the terms of the **Compliance Addendum** will prevail, but only with respect to the particular Plan and/or Product Category or service.

9.2 **Waiver/Governing Law/Severability/No Third Party Beneficiaries/Headings**. The waiver by either Party of a breach or violation of any provision of this Agreement will not operate as or be construed to be a waiver of any subsequent breach of this Agreement. Except as otherwise required by Applicable Law and/or an applicable **Compliance Addendum**, this Agreement will be governed in all respects by the laws of the state where Service Provider is located, without regard to such state's choice of law provisions. Any determination that any provision of this Agreement or any application of it is invalid, illegal or unenforceable in any respect in any instance will not affect the validity, legality and enforceability of such provision in any other instance, or the validity, legality or enforceability of any other provision of this Agreement. Other than as expressly set forth in this Agreement, no third persons or entities are intended to be or are third party beneficiaries of or under the Agreement, including, but not limited to, Members. Headings in the Agreement are for convenience only and do not affect the meaning of the Agreement.

9.3 **Insurance**. Company agrees to procure and maintain such policies of general and other insurance, and/or maintain an appropriate program of self-insurance, as shall be necessary to insure Company and its employees against any claim(s) for damages arising in connection with the performance of Company's obligations under this Agreement. Service Provider agrees to procure and maintain and to require each Network Provider to procure and maintain such policies of general and professional liability and other insurance at minimum levels required by state law, or in the absence of state law specifying a minimum limit, an amount customarily maintained by similarly situated providers of similar services in the state(s) or region(s) in which they operate.

9.4 **Limitation of Liability**. A Party's liability, if any, for damages to the other Party related to this Agreement, will be limited to the damaged Party's actual damages. Neither Party will be liable to the other for any indirect, incidental, punitive, exemplary, special or consequential damages of any kind. This section will survive the termination of this Agreement.

9.5 **Assignment**. Service Provider may not assign this Agreement without Company's prior written consent. Company may assign this Agreement, in whole or in part, from time to time. To support a partial assignment, Company may

duplicate this Agreement, including one or more of the relevant **Product Addenda** and **Service and Rate Schedules**, and assign the duplicate while retaining all or part of the original. If Company sells all or a portion of a Product Category in which Provider participates (e.g., a line of business), Company may also create and assign to the purchaser a duplicate of this Agreement including the relevant **Product Addenda** and **Service and Rate Schedules**. If Company assigns this Agreement to any entity other than an Affiliate, Company will provide advance written notice to Service Provider.

9.6 **Amendments**. This Agreement will be deemed to be automatically amended to conform with all Applicable Law (which includes any updates to OhioRise Program CME requirements) promulgated at any time by any state or Federal regulatory agency, governmental authority or applicable accreditation agency. Notwithstanding the foregoing, at Company's discretion, Company may amend this Agreement upon written notice to Service Provider by letter, newsletter, or electronic or other commonly accepted media, to comply with Applicable Law (which includes any updates to OhioRise Program CME requirements).

9.7 **Notices**. Notices required to terminate or non-renew the Agreement or to decline participation in a new Product Category or Plan/program, must be sent by U.S. mail or nationally recognized courier, return receipt requested, to the applicable Party's most currently updated address. Any other notices required under this Agreement may be sent by letter, electronic mail or other generally accepted media, to the applicable Party's last updated address.

9.8 **Non-Exclusivity**. This Agreement is not exclusive and does not preclude either Party from contracting with any other person or entity for any purpose. Without limiting the generality or scope of the foregoing, Service Provider acknowledges and agrees that Company shall have the right to contract directly with any and all Network Providers, whether in connection with a Plan, this Agreement, or otherwise. Company makes no representation or guarantee as to the number of Members who may select or be assigned to any Network Provider(s).

9.9 **Subcontractors**. Service Provider may not subcontract or delegate any of its obligations under this Agreement, in whole or in part, without the prior written consent of Company, which consent may be withdrawn for good cause. Service Provider specifically agrees that it shall require any and all of its subcontractors to comply with the terms of this Agreement, including, but not limited to, requiring subcontractors to permit audits as specified herein. Service Provider shall be responsible for the acts and omissions of its subcontractors to the extent permitted by Applicable Law.

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DEFINITIONS

In addition to terms defined in the first paragraph of the Agreement and in various exhibits hereto, the following capitalized terms have the following meanings:

Affiliate. Any corporation, partnership or other legal entity, that is directly or indirectly owned or controlled by, or which owns or controls, or which is under common ownership or control with Company. Plans may be offered by separate Company Affiliates and each of those Affiliates is considered to be a Party to this Agreement.

Applicable Law. All applicable Federal and state laws, regulations and governmental directives related to this Agreement, as well as, with respect to Service Provider and Network Providers, applicable accreditation agency/organization requirements.

Catchment Area. The area within the State of Ohio based on the projected annual population of the OhioRISE Program in which the Service Provider will provide the Services. For purposes of this Agreement, the Service Provider's catchment area shall be ______________________.

CME. Care Management Entity that serves as the "locus of accountability" for youth with complex challenges and their families/caregivers by delivering care coordination through ICC and MCC.

Covered Services. Those health care and/or other services for which a Member is entitled to receive coverage or program benefits under a Plan.

High-Fidelity Wraparound. The National Wraparound Initiative defines High Fidelity Wraparound as a comprehensive, holistic, youth and family-driven way of responding when children or youth experience serious mental health or behavioral challenges. Wraparound puts the child or youth and family at the center. With support from a team of professionals and natural supports, the family's ideas and perspectives about what they need and what will be helpful drive all of the work in Wraparound (Regional Research Insititute, School of Social Work, Portland State University, 2021). High Fidelity Wraparound operationalizes ten principles when working with youth and caregivers:

1. **Family/Caregiver Voice and Choice**: Family/caregiver and youth perspectives are intentionally elicited and prioritized during all phases of the wraparound process. Planning is grounded in family/caregiver perspectives, and the team strives to provide options and choices such that the plan reflects family/caregiver values and preferences.
2. **Team based**: The wraparound team consists of individuals agreed upon by the family/caregiver and committed to the family/caregiver through informal, formal, and community support and service relationships.
3. **Natural supports**. The team actively seeks out and encourages the full participation of team members drawn from family/caregiver networks of interpersonal and community relationships. The wraparound plan reflects activities and interventions that draw on sources of natural support.
4. **Collaboration**. Team members work cooperatively and share responsibility for developing, implementing, monitoring, and evaluating a single wraparound plan. The plan reflects a blending of team members' perspectives, mandates, and resources. The plan guides and coordinates each team member's work towards meeting the team's goals.
5. **Community based**. The wraparound team implements service and support strategies that take place in the most inclusive, most responsive, most accessible, and least restrictive settings possible; and that safely promote youth and family/caregiver integration into home and community life.
6. **Culturally competent**. The wraparound process demonstrates respect for and builds on the values, preferences, beliefs, culture, and identity of the youth and family/caregiver, and their community.
7. **Individualized**. To achieve the goals laid out in the wraparound plan, the team develops and implements a customized set of strategies, supports, and services.
8. **Strengths based**. The wraparound process and the wraparound plan identify, build on, and enhance the capabilities, knowledge, skills, and assets of the youth and family/caregiver, their community, and other team members.
9. **Unconditional**. A wraparound team does not give up on, blame, or reject youth or their family/caregiver. When faced with challenges or setbacks, the team continues working towards meeting the needs of the youth and family/caregiver and towards achieving the goals in the wraparound plan until the team reaches agreement that a formal wraparound process is no longer necessary.

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10. **Outcome based**. The team ties the goals and strategies of the wraparound plan to observable or measurable indicators of success, monitors progress in terms of these indicators, and revises the plan accordingly.

Individual Sites. Individual Service Provider facilities and/or centers that are owned and/or operated by Service Provider (and including employed and/or contracted personnel providing services at such sites).

Intensive Care Coordination. Intensive care coordination (ICC) using High-Fidelity Wraparound is utilized when a 'child and adolescent needs and strengths' (CANS) assessment and other clinical documentation indicates:

(a) Significant behavioral health challenges that require an action or immediate intensive action to ensure that the identified behavioral health needs, risk behaviors, life functioning and caregivers needs are addressed; and

(b) The youth requires the majority of care coordination activities be delivered in the community; and one of the following:

(i) The youth demonstrates at risk behaviors or other psychosocial factors which place the youth at high likelihood for out of home treatment or psychiatric hospitalization.;
(ii) The youth is awaiting out of home behavioral health treatment;
(iii) The youth is being discharged or has recently been discharged from a PRTF, as described in inpatient psychiatric hospitalization or other residential treatment facility and is returning to a community setting; or
(iv) The youth has had multiple episodes of inpatient psychiatric hospitalization, or other institutional or residential community based treatment facility stays within the past 12 months.

Member. A person covered by or enrolled in a Plan. Member includes the subscriber and any of the subscriber's eligible dependents.

Moderate Care Coordination. Moderate care coordination (MCC) using a wraparound informed model is utilized when a CANS assessment and other clinical documentation indicates:

(a) Moderate behavioral health challenges that require an action or immediate intensive action to ensure that the identified behavioral health needs, risk behaviors, and life functioning are addressed; and one of the following:

(i) The youth demonstrates at risk behaviors or other psychosocial factors which place the youth at moderate risk for out of home treatment or psychiatric hospitalization.;
(ii) The youth has had an episode of inpatient psychiatric hospitalization, or other institutional or community based behavioral health treatment facility stay within the past 12 months; or
(iii) The youth is currently involved with two or more child serving systems, which includes either child welfare, detention, or juvenile justice.

Network. Service Provider's network of Network Providers accessed by Company under this Agreement.

Network Provider. A behavioral health or mental health provider accepted for participation in Company's applicable network(s), who is employed by and/or contracted with Service Provider or who otherwise bills or is reimbursed for services under this Agreement, whether on a regular or on call basis. Unless excluded at Company's discretion, the term Network Provider includes all of the persons and entities that provide services to Members in any of Service Provider's Individual Sites and/or any Network Provider's practice arrangements or locations and under any of its/their tax identification numbers, unless specifically excluded under this Agreement or as otherwise approved, in advance, in writing, by Company.

Network Provider Contract. A direct agreement between Service Provider and each Network Provider as defined in Section 1 above.

ODM. Ohio Department of Medicaid.

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OhioRISE Program. The Ohio Resilience through Integrated Systems and Excellence (OhioRISE) Program developed to improve care for youth with complex behavioral health needs and their families/caregivers by (i) creating a seamless delivery system for children, families and system partners; (ii) providing a "locus of accountability" by offering intensive care coordination; and (iii) expanding access to critical services needed for this population and assisting families, state and local child serving agencies, and other health providers to locate and use necessary services.

Participating Provider. A person or entity that participates in Company's participating provider network(s) for the applicable Plan.

Participation Criteria. The participation criteria (e.g., office standards, DEA requirements, etc.) that apply to various types of Participating Providers under Company Policies.

Party. Company or Service Provider, as applicable.

Payer. A person or entity that is authorized to access one or more networks of Participating Providers and that: (a) is financially responsible for funding or underwriting payments for benefits provided under a Plan; or (b) is not financially responsible to fund or underwrite benefits, but which contracts directly or indirectly with persons or entities that are financially responsible to pay for Covered Services provided to Members. Payers include, but are not limited to, Company, insurers, self-funded employers, third party administrators, labor unions, trusts, and associations.

Plan. A health care benefits plan or program for which Service Provider (and/or Network Providers, as the case may be) serve as Participating Providers; the terms of each specific Plan are outlined in the applicable summary plan description, certificate of coverage, evidence of coverage, or other coverage or program document.

Policies. Company's policies and procedures that relate to this Agreement, including, but not limited to, Participation Criteria; Provider Manuals; clinical policy bulletins; credentialing/recredentialing, utilization management, quality management, audit, coordination of benefits, complaint and appeals, security and other policies and procedures (as modified from time to time), that are made available to Service Provider electronically or through other commonly accepted media. Policies may vary by Affiliate, Product Category and/or Plan.

Product Category. A category of health benefit plans or products (e.g., Commercial Health, Medicare) in which Service Provider (and/or Network Providers, as the case may be) participate under this Agreement, as noted on the Signature Page to this Agreement and more fully described on the applicable **Product Addendum(a)**.

Provider Manual. Company's handbook(s), manual(s) and guide(s) applicable to various types of Participating Providers, Product Categories and/or programs.

Work Product. If applicable to this Agreement, all tangible property, technical notes, ideas and inventions, reports, including, without limitation, all software and all documentation relating to any software, and all other tangible work product, whether in final or draft form, required to be delivered and/or produced or created by Service Provider and/or Network Provider(s) in the performance of its obligations under this Agreement.

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MEDICAID PRODUCT ADDENDUM

For purposes of the Agreement and this Medicaid Product Addendum (this "Addendum"), the capitalized terms "Plan(s)" and "Product Category(ies)" shall each include Medicaid Products, as defined below.

1. **Definitions**.

   a. Government Sponsor(s). A state agency or other governmental entity authorized to offer, issue, and/or administer a Medicaid Product, and which, to the extent applicable, has contracted with Company to operate and/or administer all or a portion of such Medicaid Product.

   b. Medicaid Product(s). Those Plans, products, and other health benefit programs set forth on **Exhibit A – Affiliate Listing & Product Participation**.

   c. State Contract(s). Company's contract(s) with Government Sponsor(s) to operate and/or administer one or more Medicaid Products.

2. **Payment for Covered Services**. The compensation set forth in **Exhibit B – Service and Rate Schedule (Medicaid Products)** shall *only* apply to services rendered to Members covered under the Medicaid Products set forth therein. Service Provider acknowledges and agrees that if an Affiliate of Company is the Payer for a particular Medicaid Product, such Affiliate's duties, obligations, and liabilities under the Agreement shall be strictly limited to the services rendered to Members covered under that Medicaid Product.

3. **Overpayments to Provider**. If Service Provider identifies an overpayment that it received relating to any Medicaid Product, Service Provider shall comply with Section 6402(a) of the Patient Protection and Affordable Care Act (currently codified at 42 U.S.C. § 1320a-7k(d)) and its implementing regulations. In addition to Company's other overpayment-recovery rights, Company shall have the right to recover from Service Provider any payment that corresponds to services previously rendered to an individual whom Company later determines, based on information that was unavailable to Company at the time the service was rendered or authorization was provided, to have been ineligible for coverage under a Medicaid Product when such service was rendered.

4. **Medicaid Product/State Contract Requirements**. Because Company is a party to one or more State Contracts, Service Provider and Network Providers must comply with Applicable Law, with certain provisions of the State Contracts, and with certain other requirements that are uniquely applicable to the Medicaid Products. Some, but not all, of these provisions and requirements are set forth in **Exhibit __ – State Compliance Addendum (Medicaid Products)** and/or the Provider Manual for the Medicaid Products, both of which are incorporated herein and binding on the Parties. Service Provider agrees and shall require Network Providers to agree that all provisions of this Addendum shall apply equally to any employees, independent contractors, and subcontractors that Service Provider or Network Provider engages in connection with the Medicaid Products, and Service Provider or Network Provider, as applicable, shall cause such employees, independent contractors, and subcontractors to comply with this Addendum, the State Contract(s), and Applicable Law. Any subcontract or delegation to be implemented in connection with the Medicaid Products shall be subject to prior written approval by Company, shall be consistent with this Addendum, the State Contract(s), and Applicable Law, and may be revoked by Company or a Government Sponsor if the performance of the subcontractor or delegated person or entity is unsatisfactory. Service Provider acknowledges and shall require Network Providers to acknowledge that the compensation it receives under this Addendum constitutes the receipt of federal funds.

5. **The Federal 21st Century Cures Act ("Cures Act")**. Service Provider acknowledges and agrees and shall require Network Providers to agree that because Service Provider and/or Network Providers furnish items and services to, or order, prescribe, refer, or certify eligibility for services for, individuals who are eligible for Medicaid and who are enrolled with Company under a Medicaid Product, Network Providers and Service Provider, as applicable, shall maintain enrollment, in accordance with Section 5005 of the Cures Act, with the Medicaid program of the Government Sponsor of that Medicaid Product. If Network Providers or Service Provider, as applicable, fail to enroll in, are not accepted to, or are disenrolled or terminated from the Medicaid program of that Government Sponsor, Network Provider or Service Provider, as applicable, shall be terminated as a Participating Provider for that Medicaid Product.

6. **Government Approvals**. One or more Government Sponsors or other governmental authorities may recommend or require that the Parties enter into the Agreement, including this Addendum, prior to execution of a State Contract and/or

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prior to issuance to Company of one or more government approvals, consents, licenses, permissions, bid awards, or other authorizations (collectively, the "Government Approvals"). Service Provider acknowledges and agrees that all Company obligations to perform, and all rights of Service Provider, under the Agreement as it relates to the Medicaid Products are conditioned upon the receipt of all Government Approvals. The failure or inability of Company to obtain any Government Approvals shall impose no liability on Company under the Agreement as it relates to the Medicaid Products.

7. **Immediate Termination or Suspension Due to Termination of State Contract**. This Addendum and/or the Agreement may be terminated or suspended by Company, or an Affiliate may be removed from the Agreement, upon notice to Service Provider and at Company's discretion, without liability to Company, if a State Contract expires or is suspended, withdrawn, or terminated.

8. **Termination of Medicaid Product Addendum**. In the event this Addendum is terminated for any reason, such termination shall not in and of itself constitute termination of any of Company's other products, Plans or programs.

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EXHIBIT A

AFFILIATE LISTING & PRODUCT PARTICIPATION

Service Provider and Network Providers shall be Participating Providers in the network(s) of the following (all together, the "Medicaid Products"):

A. The OhioRISE Plan offered by Company within Ohio.

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EXHIBIT B

SERVICE AND RATE SCHEDULE (MEDICAID PRODUCTS)

1.0 SERVICES & COMPENSATION

Company, or the applicable Affiliate that is the Payer responsible for a particular Medicaid Product, shall compensate Service Provider for the Covered Services that Network Providers render to Members covered under that Medicaid Product, and shall do so on a timely basis, consistent with the claims-payment procedure described in 42 U.S.C. § 1396a(a)(37)(A) and subject to the terms of the Agreement, according to the following rates *or* Service Provider's actual billed charges, whichever is less:

OhioRISE Plan: 100% Aetna Medicaid Market Fee Schedule

2.0 DEFINITIONS

A. Aetna Medicaid Market Fee Schedule (AMMFS) is defined as a fee schedule that is based upon the contracted location where service is performed and the applicable State Medicaid Fee Schedule.

3.0 TERMS AND CONDITIONS

A. Capitation. As full compensation for Covered Services and other services provided by Service Provider and Network Providers under this Agreement, including attendant costs associated with the administration, overhead and delivery of such Network/services (e.g., without limitation, applicable documentation and records retention), Service Provider shall be paid a capitation per member per month (PMPM) amount ("Capitation Payment").

B. Other Compensation Terms. The Capitation Payment shall be based on the number of Members assigned to Company on the first day of the month and shall be issued to Service Provider by the fifteen (15th) of the month. Service Provider agrees that it shall not pay any Network Provider more or less than 100% of the State Medicaid Fee Schedule without prior written approval from Company. Company has the right to recover payments for individuals that Company later determines are not Members.

C. Adequacy. Service Provider acknowledges the financial risks to Service Provider of this arrangement and has made an independent analysis of the adequacy of this arrangement. Service Provider waives any and all claims that it was in any way improperly induced by Company to accept the rate of payment, including, but not limited to, any cause of actions for damages, rescission or termination alleging fraud or negligent misrepresentation or improper inducement.

D. Encounter Data. Without limitation of other requirements in this Agreement or the Delegated Services Addendum or Delegation Agreement, Service Provider will submit encounter data to Company in a format and frequency specified by Company and/or as necessary for Company to meet its reporting requirements to applicable Government Sponsors.

E. Additional Compensation. Company may, from time to time and in its discretion, offer additional compensation to Provider in connection with Member health, quality improvement and/or care management services provided (e.g., additional well visit coverage for Members, enhanced care management outreach).

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EXHIBIT C

STATE COMPLIANCE ADDENDA (MEDICAID PRODUCTS)

The Parties acknowledge that each State Compliance Addenda that follows shall apply to the extent that (i) Company offers Medicaid Products in such State and (ii) Service Provider and/or Network Providers provide services or items in such State.

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