AmeriHealth Caritas Ohio, Inc.

ANCILLARY SERVICES AGREEMENT

with

[PROVIDER NAME]

AmeriHealth Caritas Ohio, Inc.
ANCILLARY SERVICES AGREEMENT

This Provider Services Agreement (the "Agreement"), dated as of the Effective Date (defined below), is made by and between AmeriHealth Caritas Ohio, Inc., a corporation organized under the laws of the State of Ohio, (hereinafter referred to as "ACOH") and the Provider ("Provider") identified on the signature page.

WHEREAS, ACOH is a managed care organization that is responsible for providing or arranging for the provision of health care services to its Members; and

WHEREAS, Provider is duly licensed to furnish certain health care services; and

WHEREAS, Provider and ACOH mutually desire to enter into this Agreement, whereby Provider shall render services to Members enrolled with ACOH and be compensated by ACOH in accordance with the terms and conditions hereof.

NOW, THEREFORE, in consideration of the mutual promises made herein, it is mutually agreed by and between ACOH and Provider as follows:

1. DEFINITIONS

As used in this Agreement, each of the following terms shall have the meaning specified herein, unless the context clearly requires otherwise.

1.1 **AFFILIATES.** An Affiliate is any corporation or other organization that is identified as an Affiliate in a written notice to Provider and is owned or controlled, either directly or through parent or subsidiary corporations, by or under common control with, ACOH. ACOH shall give Provider thirty (30) days advance written notice of the addition of Affiliates added under this provision. Unless otherwise specified in this Agreement or any other attachment hereto, references to "ACOH" shall include the Affiliates referenced in **Appendix B**.

1.2 **AGENCY.** The State and/or Federal governmental agency that administers the Program(s) under which ACOH is obligated to provide or arrange for the provision of Covered Services.

1.3 **AGENCY CONTRACT.** The contract or contracts between ACOH and the Agency, as in effect from time to time, pursuant to which ACOH is responsible for coordinating health care services and supplies for Program recipients enrolled with ACOH.

1.4 **CLEAN CLAIM.** A claim for payment for a health care service, which has been received by ACOH, has no defect or impropriety. A defect or impropriety shall include a lack of required substantiating documentation or a particular circumstance requiring special treatment that prevents timely payment from being made on the claim. Consistent with **42 CFR §447.45(b)**, the term shall not include a claim from a health care provider who is under investigation for fraud or abuse regarding that claim, or a claim under review for medical necessity.

1.5 **COVERED SERVICES.** Those Medically Necessary health care services and supplies to which Members are entitled pursuant to the Agency Contract, and which shall be provided to Members by Provider, as described more specifically in **Appendix A**. Covered Services shall be furnished in the

amount, duration and scope required under the Program. Without limiting the foregoing, Covered Services may be furnished through telehealth (as defined in OAC 5160-1-18 (the "Ohio Telehealth Rule")), subject to all applicable requirements of the Ohio Telehealth Rule being met, including but not limited to requirements for provider type.

1.6 **EFFECTIVE DATE.** The later of (i) the effective date on the signature page of this Agreement or (ii) the effective date of the Agency Contract, provided that Provider has been successfully credentialed, as applicable, and that all required regulatory approvals have been obtained by ACOH.

1.7 **EMERGENCY MEDICAL CONDITION.** Health care services provided to a Member after the sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity or severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

(a) Placing the health of the Member (or with respect to a pregnant woman, the health of the Member or her unborn child) in serious jeopardy;

(b) Serious impairment to bodily functions; or

(c) Serious dysfunction of any bodily organ or part.

1.8 **EMERGENCY SERVICES.** Covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish these services under 42 C.F.R. Section 438.114(a) and 42 U.S.C. Section 1932(b)(2) and that are needed to screen, evaluate, and stabilize an Emergency Medical Condition.

1.9 **MEDICALLY NECESSARY.** "Medical Necessity" is defined in accordance with OAC §5160-1-01, which provides as follows:

(a) Medical necessity for individuals covered by early and periodic screening, diagnosis and treatment (EPSDT) is defined as procedures, items, or services that prevent, diagnose, evaluate, correct, ameliorate, or treat an adverse health condition such as an illness, injury, disease or its symptoms, emotional or behavioral dysfunction, intellectual deficit, cognitive impairment, or developmental disability.

(b) Medical necessity for individuals not covered by EPSDT is defined as procedures, items, or services that prevent, diagnose, evaluate, or treat an adverse health condition such as an illness, injury, disease or its symptoms, emotional or behavioral dysfunction, intellectual deficit, cognitive impairment, or developmental disability and without which the person can be expected to suffer prolonged, increased or new morbidity; impairment of function; dysfunction of a body organ or part; or significant pain and discomfort.

(c) Conditions of medical necessity are met if all the following apply: (i) meets generally accepted standards of medical practice; (ii) clinically appropriate in its type, frequency, extent, duration, and delivery setting; (iii) appropriate to the adverse health condition for which it is provided and is expected to produce the desired outcome; (iv) is the lowest cost alternative that effectively addresses and treats the medical problem; (v) provides unique, essential, and appropriate information if it is used for diagnostic purposes; and (vi) not provided primarily for the economic benefit of the provider nor for the convenience of the provider or anyone else other than the recipient.

(d) The fact that a physician, dentist or other licensed practitioner renders, prescribes, orders, certifies, recommends, approves, or submits a claim for a procedure, item, or service does not, in and of itself, make the procedure, item, or service medically necessary and not guarantee payment for it.

(e) More specific criteria regarding the conditions of medical necessity for particular categories of service may set forth within Agency coverage policies or rules.

1.10 **MEMBER.** An individual who is eligible for the Program and who has enrolled in ACOH under the Program.

1.11 **MEMBER APPEAL PROCEDURES.** The written procedures describing ACOH's standards for the prompt resolution of Member problems, grievances and appeals, as described in the Provider Manual.

1.12 **PARTICIPATING PROVIDER.** A duly licensed or certified, as applicable, health care provider that has entered into an agreement with ACOH to provide health care services to Members.

1.13 **PROGRAM.** The Ohio Medicaid managed care program.

1.14 **PROVIDER MANUAL.** The ACOH manual of standards, policies, procedures and corrective actions together with amendments or modifications ACOH may adopt from time to time. The Provider Manual is herein incorporated by reference and made part of this Agreement. The Provider Manual may be amended or modified by ACOH from time to time in accordance with Section 3.3 herein below.

1.15 **QUALITY MANAGEMENT PROGRAM.** An ongoing review process and plan which functions to define, monitor, review, and recommend corrective action for managing and improving the quality of health care services to Members.

1.16 **UTILIZATION MANAGEMENT PROGRAM.** A process of review of the medical necessity, appropriateness and efficiency of health care services, procedures, equipment, supplies, and facilities rendered to Members.

2. OBLIGATIONS OF PROVIDER:

2.1 Throughout the term of this Agreement, Provider shall have and maintain, without restriction, all licenses, certificates, registrations and permits as are required under applicable State and federal statutes and regulations to provide the Covered Services furnished by Provider and/or other related activities delegated by ACOH under this Agreement. Provider shall obtain a unique identifier (national provider identifier) in accordance with the system established under Section 1173(b) of the Social Security Act, submit such identifier number to ACOH, and include such identifier on all claims. At all times during the term of this Agreement, Provider shall participate in the Ohio Medicaid program and be enrolled with the Agency. To the extent that Covered Services are furnished to Medicare beneficiaries under this Agreement, Provider shall also participate in the Medicare program. Provider shall ensure that all services provided pursuant to this Agreement are within the Provider's scope of professional responsibility.

2.2 Provider must be successfully credentialed by ACOH prior to providing services to Members; provided, however, that once Agency implements its centralized credentialing process: (i) Provider must be successfully credentialed or approved through Agency's process prior to

providing services to Members; and (ii) ACOH will no longer credential Provider if Provider is enrolled with the Agency. Provider shall provide to Members the Covered Services described in **Appendix A** hereto; provided, however, that Provider shall only be obligated to provide Covered Services to a Member in accordance with ACOH's pre-authorization and other Utilization Management Program policies as described in the Provider Manual, other than Emergency Services, which will be provided as needed. In providing Covered Services, Provider agrees to abide by the relevant standards, policies and procedures of ACOH, including, but not limited to administrative, credentialing, quality management, utilization management, and Member Appeal Procedures set forth in the Provider Manual and other ACOH notices. Provider shall provide Covered Services in the same manner and with the same availability as services provided to other patients without regard to reimbursement and shall further provide these services in the most cost effective setting in accordance with appropriate quality of care and performance standards which are professionally recognized as industry standards and/or otherwise adopted, accepted or established by ACOH.

2.3 Provider shall provide ACOH with complete and accurate statements of all Covered Services provided to Members in conformance with ACOH billing procedures as set forth in the applicable Program manuals, the Provider Manual and other written ACOH billing guidelines. ACOH will not be liable for any bills relating to services that are submitted the later of: (a) after twelve (12) months from the date the services were provided (consistent with **42 CFR §447.45(d)**), or (b) after sixty (60) days of the date of the Explanation of Benefits from another payor when services are first billed by Provider to another payor. Any appeal or request for adjustment of a payment by Provider must be made in accordance with applicable provisions of the Provider Manual and ACOH policies and procedures and, in any case, must be received by ACOH within the later of: (i) twelve (12) months from the date of service, or (ii) sixty (60) calendar days after the original payment, denial or partial denial; or within such other time period as may be required by the Agency. Provider may not bring legal action on claims which have not been appealed through the appeal mechanisms described herein.

Encounter Data and Other Reports. Provider shall deliver all reports and clinical information required to be submitted to ACOH pursuant to this Agreement for reporting purposes, including but not limited to encounter data, Healthcare Effectiveness Data and Information Set (HEDIS), Agency for Healthcare Research and Quality (AHRQ), and EPSDT data in a format which will allow ACOH to transmit required data to the Agency electronically and in a format identical to or consistent with the format used or otherwise required by ACOH and the Agency. Provider shall submit this information to ACOH within the time frames set forth in the Provider Manual or as otherwise required by the Agency. Provider shall submit all encounter data to the same standards of completeness and accuracy as required for proper adjudication of fee-for-service claims by ACOH.

2.4 Provider may directly bill Members for non-Covered Services if the Member is advised in writing before the service is rendered: (i) the nature of the service(s) to be rendered; (ii) that ACOH does not cover the services; and (iii) that the Member will be financially responsible for the services if the Member elects to receive the services. Furthermore, Provider shall hold harmless ACOH for any claim or expense arising from such services.

2.5 Provider shall not bill or collect from any Member any amount or charges for any Covered Services provided hereunder, except for authorized co-payments, co-insurance, and/or deductibles. Provider shall not deny Covered Services to a Member in the event that a Member is unable to pay any authorized co-payment amounts. **42 CFR §447.15**.

2.6 Under no circumstances, including ACOH's failure to pay for Covered Services, termination of this Agreement, or the insolvency of ACOH, will Provider make any charges or claims against any Member directly or indirectly for Covered Services authorized by ACOH, except for authorized co-payments. Provider shall look only to ACOH for compensation for Covered Services.

2.7 During the term of this Agreement and in the event of termination of this Agreement for any reason, Provider agrees to fully cooperate with each Member and with ACOH in arranging for the transfer of copies of Member medical records to other ACOH Participating Providers.

2.8 Record Maintenance, Inspection, Reporting and Auditing

(a) Record Retention. As required by **42 CFR 434.6(a)(7)** and otherwise in accordance with the standards of ACOH, Provider shall maintain an adequate record system for recording services, service providers, charges, dates and all other commonly required information elements for services rendered to Members pursuant to this Agreement (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under this Agreement and the Agency Contract).

(b) All records originated or prepared in connection with Provider's performance of its obligations under this Agreement will be retained and safeguarded by Provider in accordance with the terms and conditions of the Agency Contract and other relevant State and federal law. Provider agrees to retain all financial and programmatic records, supporting documents, statistical records and other records of Members relating to the delivery of care or service under the Agency Contract and as further required by the Agency, for a period of no less than ten (10) years from the expiration date of the Agency Contract, including any contract extension(s). If any audit, litigation, claim, or other actions involving the records have been initiated prior to the expiration of the ten (10) year period, the records shall be retained until completion of the action and resolution of all issues which arise from it or until the end of the ten (10) year period, whichever is later. If Provider stores records on microfilm or microfiche or other electronic means, Provider agrees to produce, at its expense, legible hard copy records promptly upon the request of state or federal authorities.

(c) Medical Record Maintenance. Provider shall ensure that all medical records are in compliance with the medical record keeping requirements set forth in the Provider Manual, the Agency Contract and Agency guides. Provider shall maintain up-to-date medical records at the site where medical services are provided for each Member enrolled under this Agreement. Each Member's record must be accurate, legible and maintained in detail consistent with good medical and professional practice which permits effective internal and external quality review and/or medical audit and facilitates an adequate system of follow-up treatment.

(d) ACOH shall be entitled to audit, examine and inspect Provider's books and records, including but not limited to medical records, financial information and administrative information pertaining to Provider's relationship with ACOH, at any time during normal business hours, upon reasonable notice. Provider agrees to provide ACOH, at no cost to ACOH, with such medical, financial and administrative information, and other records as may be necessary for ACOH to meet its obligations related to the Agency Contract and other regulatory obligations, Utilization Management Program and Quality Management Program standards, including NCQA standards, and other relevant accreditation standards which ACOH may require of ACOH Participating Providers.

2.9 Provider authorizes ACOH to include Provider's name, address, telephone number, information related to Provider's facilities, services and staff, and other similar information relevant to Provider, its operations and staff in the ACOH provider directory and in various marketing materials identifying Provider as a provider of services to Members. Provider agrees to afford ACOH the same opportunity to display brochures, signs, or advertisements in Provider's facilities as Provider affords any other insurance company or other third party payor.

2.10 While both parties support Provider's open and active communication with Members concerning Medically Necessary services, available treatment alternatives, benefit coverage information and/or any other information pertaining to the provider-patient relationship, Provider shall not, during the term of this Agreement, and any renewal thereof, solicit or require any Member, either orally or in writing, to subscribe to or enroll in any managed care plan other than ACOH. The provisions of this Section 2.10 shall similarly apply to Provider's employees, agents and/or contractors.

2.11 Provider shall cooperate with ACOH in the identification of other sources of payment available to Members, such as other health insurance, government programs, liability coverage, motor vehicle coverage or worker's compensation coverage, as applicable. Provider shall be responsible for reporting all applicable third party resources to ACOH in a timely manner.

Provider will cooperate with ACOH in coordinating benefits with other payors in accordance with coordination of benefits claim processing rules and requirements outlined in the Provider Manual, the Agency Contract, and applicable Program manuals, as amended from time to time. Provider will make a reasonable attempt to determine whether any other payor has primary responsibility for the payment of a claim for services that Provider rendered to a Member and bill that payor before billing ACOH. Unless otherwise prohibited by applicable law, ACOH retains the right to recover payments made to Provider in the event ACOH determines that another payor is primarily responsible for all or a portion of the claim.

2.12 Provider understands and agrees that any payments ACOH makes directly or indirectly to Provider under this Agreement shall not be made as an inducement to reduce, limit or delay Medically Necessary services to any Member.

2.13 Provider will refer Members to ACOH-participating hospitals whenever Provider is unable to provide Medically Necessary services and when consistent with sound medical judgment and accepted standards of care.

2.14 Provider shall use the Agency's designated electronic utilization management and claims interfaces to improve the efficiency of utilization management and claims payment processes.

2.15 Provider will assist ACOH in providing orientation services to Provider staff to the extent ACOH may reasonably request.

2.16 Fraud and Abuse. Provider recognizes that payments made by ACOH pursuant to this Agreement are derived from federal and State funds, and acknowledges that it may be held civilly and/or criminally liable to ACOH and/or the Agency, in the event of non-performance, misrepresentation, fraud or abuse for services rendered to Members, including but not limited to, the submission of false claims/statements for payment by Provider, its employees or agents. Provider shall be required to comply with all policies and procedures as developed by ACOH and the Agency, including but not limited to the requirements set forth in the Provider Manual and the

Agency Contract, for the detection and prevention of fraud and abuse. Such compliance may include, but not be limited to, referral of suspected or confirmed fraud or abuse to ACOH.

2.17 Provider will deliver location-based services to Members only at those service locations set forth in **Appendix C** hereto as such appendix is modified from time to time by mutual agreement of the parties. Provider shall notify ACOH at least sixty (60) days prior to making any addition or change to service locations.

3. OBLIGATIONS OF ACOH:

3.1 ACOH shall pay Provider for Covered Services provided to Members pursuant to the terms of this Agreement. ACOH shall have the right to offset claims payments to Provider by any amount owed by Provider to ACOH, following at least thirty (30) days' written notice and the conclusion of any associated provider dispute. Provider shall not be entitled to reimbursement if the Member was not eligible at the time services were rendered, and ACOH may recover any amounts paid for services rendered to an ineligible recipient following at least thirty (30) days' written notice and the conclusion of any associated provider dispute.

Overpayment Recovery. Provider shall report to ACOH when it has received an overpayment, notify ACOH in writing of the reason for the overpayment, and return the overpayment to ACOH within sixty (60) calendar days after the date on which the overpayment was identified.

The Agency may recover any overpayment paid from ACOH to Provider if the Agency identifies the overpayment during the five-year period immediately following the end of the state fiscal year in which the overpayment was made, consistent with **O.R.C. §5164.57**.

3.2 ACOH shall compensate Provider for Covered Services provided to Members upon receipt of a statement thereof, as defined in Section 2.3, and in accordance with Section 2.11 and the Covered Services Payment Schedule set forth in **Appendix A-1** but, in no event, will ACOH's payment exceed submitted charges. No additional charges will be made by Provider to ACOH for Covered Services provided hereunder, and Provider recognizes and accepts the fees set forth in **Appendix A-1** as payment in full.

3.3 ACOH will establish payment policies for inpatient and outpatient services including, but not limited to, policies with respect to the application of claim edits, pre-admission testing, services included in inpatient rates and services included in outpatient rates. ACOH will provide at least thirty (30) days' prior written notice of any modifications to such payment policies. ACOH may, based on changes in clinical practice and modifications to standard coding systems, add and/or delete outpatient fee schedule procedures and re-categorize outpatient surgery fee schedule procedures, upon thirty (30) days' prior written notice to Provider.

3.4 ACOH shall furnish or otherwise make available to Provider a copy of the Provider Manual, as amended from time to time. Provider Manual updates will become effective thirty (30) days from the date of notification, unless otherwise specified in writing by ACOH.

3.5 ACOH shall pay all Clean Claims for Covered Services in accordance with applicable laws, regulations and Agency requirements; and ACOH will in any event meet the claim payment timeframes required under **42 CFR §447.45(d)**. In its processing of claims, ACOH will apply claim edits based on sources that include CMS and state-specific policy, as set forth in the Provider Manual.

3.6 Provider Protections.

(a) ACOH shall not exclude or terminate Provider from ACOH's provider network because the Provider advocated on behalf of a Member including in the context of a utilization management appeal or another dispute with ACOH over appropriate medical care, provided that such advocacy is consistent with the degree of learning and skill ordinarily possessed by a health care provider practicing in accordance with the applicable standard of care.

(b) No Provider shall be excluded or terminated from participation with ACOH due to the fact that the Provider has a practice that includes a substantial number of patients with expensive medical conditions.

(c) Provider shall not be excluded from participation, nor shall this Agreement be terminated, because Provider objects to the provision of or refuses to provide a healthcare service on moral or religious grounds.

4. QUALITY MANAGEMENT/UTILIZATION MANAGEMENT:

4.1 Whether announced or unannounced, Provider agrees to cooperate with, participate in, and abide by internal or external quality assessment reviews, Member Appeal Procedures, Utilization Management Program procedures, and Quality Management Program procedures established by ACOH and/or the Agency or their designees, and to follow practice guidelines as described in the Provider Manual, the Agency Contract, and the applicable Program manuals. Provider shall permit a representative of ACOH, or its designee, to review medical records concurrently as well as retrospectively. Provider shall provide copies of such medical records, either in paper or electronic form, to ACOH or its designee upon request. The Utilization Management and Quality Management Programs are described in the Provider Manual.

4.2 ACOH's Quality Management Programs consist of review of credentials and performance of ancillary and other provider types that are applying for participation in, or are participating in, ACOH's network of providers to determine whether the provider meets ACOH's standards for quality, availability, accessibility and cooperation.

4.3 ACOH's Utilization Management Programs include requirements for pre-authorization of certain services rendered in physicians' offices and in inpatient, outpatient and ancillary settings. Utilization Management Programs include concurrent, retrospective and prospective review of certain services and procedures to assure that care is delivered in the most appropriate setting and is Medically Necessary. Certain Covered Services may require prior approval from ACOH. The Covered Services subject to prior approval are more fully described in the Provider Manual and other ACOH notices. ACOH is obligated to pay for and Provider is entitled to reimbursement for only those services that are Medically Necessary. Where reimbursement for an admission, inpatient day or outpatient service is denied as not prior approved or Medically Necessary, the Provider shall not charge either ACOH or the Member for any health care services rendered or furnished with respect to such admission, inpatient day or outpatient service. If Provider disputes any such denial, the case in question shall be appealed through ACOH's provider appeal process. Provider may not bring legal action for disputes which have not been appealed through the provider appeal process.

4.4 ACOH shall monitor and report the quality of services delivered under the Agreement and initiate a plan of correction, where necessary, to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which the Provider practices and/or the standards established by ACOH, the Agency, or their

respective designees. Provider shall cooperate with and abide by any corrective action plan initiated by ACOH and/or required by the Agency or any other State or federal regulatory agency with governing authority over the services provided under this Agreement.

4.5 Provider agrees that to the extent penalties, fines or sanctions are assessed against ACOH by the Agency or another regulatory agency with governing authority over the services provided under this Agreement as a result of Provider's failure to comply with Provider's obligations under this Agreement, including but not limited to, Provider's failure or refusal to respond to ACOH's the Agency's request for medical records, applicable credentialing information, and other information required to be provided under this Agreement, Provider shall be responsible for the immediate payment of such penalties, fines or sanctions. In the event such payment is not made in a timely manner to ACOH, ACOH shall have the right to offset claims payments to Provider by the amount owed by Provider to ACOH.

5. PROFESSIONAL LIABILITY INSURANCE/ADVERSE ACTIONS:

5.1 Provider, at its sole expense, shall provide professional liability, comprehensive general liability, and, as applicable, medical malpractice insurance coverage (including coverage for vicarious liability, if any, for the acts of employees, agents and representatives of Provider) upon execution of this Agreement and at all times during the term of this Agreement, as follows:

(a) Amounts and extent of such insurance coverage as deemed necessary by ACOH to adequately insure Members and ACOH against any claim or claims for damages arising by reason of personal injury or death occasioned, directly or indirectly, in connection with Provider's performance of any service pursuant to this Agreement; in no event shall such coverage be less than the amounts required by law.

(b) Provider shall provide ACOH with written verification of the existence of such coverage upon execution of this Agreement and as otherwise requested by ACOH throughout the term of the Agreement, which may include providing copies of face sheets of such coverage. Provider shall notify ACOH reasonably in advance of any change or cancellation of such coverage.

5.2 Provider shall immediately notify ACOH in writing, by certified mail, of any written or oral notice of any adverse action, including, without limitation, litigation, investigation, complaint, claim or transaction, regulatory action or proposed regulatory action, or other action naming or otherwise involving Provider or ACOH, or any other event, occurrence or situation which may reasonably be considered to have a material impact on Provider's ability to perform Provider's duties or obligations under this Agreement. Provider also shall immediately notify ACOH of any action against any applicable license, certification or participation under Title XVIII or other applicable provision of the Social Security Act or other State or federal law, State and/or DEA narcotic registration certificate, or medical staff privileges at any facility, and of any material change in the ownership or business operations of Provider. All notices required by this Section 5.2 shall be furnished as provided in Section 10.6 of this Agreement.

5.3 Provider agrees to defend, indemnify and hold harmless ACOH and its officers, directors and employees from and against any and all claims, costs and liabilities (including the fees and expenses of counsel) as a result of a breach of this Agreement by Provider, the negligent or willful misconduct of Provider and/or Provider's employees, agents and representatives, and from and against any death, personal injury or malpractice arising in connection with the performance of any services by the Provider in connection with this Agreement. This section shall survive the termination or expiration of this Agreement for any reason.

ACOH agrees to defend, indemnify and hold harmless Provider and its officers, directors and employees from and against all claims, costs and liabilities (including the fees and expenses of counsel) as a result of ACOH's breach of this Agreement or the negligent or willful misconduct of ACOH and/or ACOH's employees, agents and representatives in connection with ACOH's performance under this Agreement. This section shall survive the termination or expiration of this Agreement for any reason.

6. CONFIDENTIALITY:

ACOH and Provider shall each comply with all applicable State and federal laws respecting the confidentiality of the medical, personal or business affairs of Members acquired in the course of providing services pursuant to this Agreement. Each party shall maintain as confidential and shall not disclose to third parties financial, operating, proprietary or business information relating to the other party which is not otherwise public information. The payment rates in this Agreement are confidential and proprietary and shall not be disclosed by either party. However, nothing herein shall prohibit either party from making any disclosure or transmission of information to the extent that such disclosure or transmission is required by the Agency or other applicable state regulatory agency, or is necessary or appropriate to enable the disclosing party to perform its obligations or enforce its rights under this Agreement, or is required by law or legal process. Should disclosure be required by law or legal process, the disclosing party shall immediately notify the other party of the disclosure.

7. COOPERATION; RESOLUTION OF DISPUTES:

7.1 Cooperation. To the extent compatible with separate and independent management of each, ACOH and Provider shall at all times maintain an effective liaison and close cooperation with each other to provide maximum benefits to Members at the most reasonable cost consistent with high standards of care. ACOH and Provider shall use best efforts to exchange information regarding material matters directly or indirectly related to this Agreement.

7.2 Resolution of Disputes. ACOH and Provider shall both fully cooperate in resolving any and all controversies among or between said parties, their employees, agents, or representatives pertaining to their respective duties under this Agreement. Such disputes shall be submitted for resolution in accordance with the provider appeal procedures as referenced in the Provider Manual and ACOH policies and procedures. Neither ACOH nor Provider shall permit a dispute between the parties to disrupt or interfere with the provision of services to Members.

8. TERM; TERMINATION:

The term of this Agreement shall commence as of the Effective Date and continue for an initial one (1) year term (the "Initial Term"). After the Initial Term, the Agreement shall automatically renew for successive one (1) year terms unless the Agreement is terminated pursuant to this Section 8 as set forth herein.

Either party may terminate this Agreement without cause at the end of the Initial Term or at the end of the subsequent terms by providing the other party with at least ninety (90) days' prior written notice before the end of the then current term. The effective date of termination without cause will be on the first of the month following the expiration of the notice period. Either party may terminate this Agreement for cause due to a material breach by giving thirty (30) days' prior written notice. The notice of termination for cause will not be effective if the breaching party cures the breach within the thirty (30) day notice period. In the event that the breaching party does not cure the breach within the thirty (30) day period, the effective date of termination will be the first of the month following the expiration of the thirty (30) day notice period.

In the event any change in federal or State laws, rules and regulations or the Ohio Medicaid Program or the Medicare Advantage program would have a material adverse impact on either ACOH or Provider in connection with the performance of this Agreement (the "Mandated Changes") such that the basis for the financial bargain of this Agreement is undermined, then the affected party shall have the right to require the other, by written notice, to enter into negotiations regarding the affected or pertinent terms of this Agreement while still maintaining the original Agreement purposes. If renegotiated, such terms shall become effective no later than thirty (30) days after the parties have reached agreement on the renegotiated terms. The parties agree to make a good faith attempt to renegotiate the Agreement to the extent necessary to comply with any Mandated Changes. If, after good faith renegotiations, the parties fail to reach an agreement satisfactory to both parties within thirty (30) days of the request for renegotiation, the party requesting such renegotiation may terminate this Agreement upon ninety (90) days prior written notice to the other party.

Notwithstanding the above, ACOH may terminate this Agreement immediately in the event any of the following occur:

8.1 If Provider is expelled, disciplined, barred from participation in, or suspended from receiving payment under any state's Medicaid program, Children's Health Insurance Program (CHIP), the Medicare Program or any other federal health care program.

8.2 If Provider is debarred, suspended or otherwise excluded from procurement or non-procurement activities under the Federal Acquisition Regulations.

8.3 Upon the loss or suspension of the Provider's liability coverage set forth under Section 5 of this Agreement.

8.4 The suspension or revocation of Provider's license or other certification or authorization, including Provider's JCAHO or other applicable accreditation, necessary for Provider to render Covered Services, or upon ACOH's reasonable determination that the health, safety or welfare of any Member may be in jeopardy if this Agreement is not terminated.

Upon termination of this Agreement for any reason, ACOH shall notify affected Members of the termination of Provider prior to the effective date of termination. Regardless of the reason for termination, Provider shall promptly supply to ACOH all information necessary for the reimbursement of outstanding claims. **42 CFR 434.6(a)(6)**.

9. REGULATORY AND PROGRAM-SPECIFIC PROVISIONS:

Attached hereto and incorporated herein by reference is **Schedule 9**, setting forth such terms and conditions as are necessary to meet State and Federal statutory and regulatory requirements, and other Agency requirements, of the Program. **Schedule 9** is consecutively sub-numbered as necessary for each Program under which Provider is furnishing services under this Agreement. Provider acknowledges that the specific terms as set forth in **Schedule 9** are subject to amendment in accordance with federal and/or State statutory and regulatory changes to the Program. Such amendment shall not require the consent of the Provider or ACOH and will be effective immediately on the effective date thereof, as set forth in Section 10.3. In the event of a conflict between the terms of this Provider Agreement and the requirements set forth in **Schedule 9**, **Schedule 9** shall control.

10. MISCELLANEOUS:

10.1 It is understood that Provider is an independent contractor and in no way is Provider to be considered an employee, agent, or representative of ACOH. It is further understood that Provider provides specified services to Members in exchange for an agreed upon fee. This Agreement shall not create, nor be deemed or construed to create any relationship between ACOH and Provider other than that of independent contractors, contracting with each other solely for the purpose of performing this Agreement and each party shall be liable solely for their own activities and neither ACOH nor Provider shall be liable to any third party for the activities of the other party to this Agreement.

10.2 This Agreement, being for the purpose of retaining the professional services of Provider, shall not be assigned, subcontracted, or delegated by Provider without the express written consent of ACOH.

10.3 No alterations or modifications of the terms of this Agreement shall be valid unless such alterations or modifications are incorporated into the Agreement through a written amendment, signed by both parties hereto, and attached to this Agreement; provided, however, ACOH may amend this Agreement with 30 days' notice to Provider via a(n) ACOH bulletin or other written communication provided in accordance with the notice provisions in Section 10.6, and unless Provider notifies ACOH, as applicable, of any objection, such amendment shall then take effect. Any amendment to this Agreement subject to prior regulatory approval(s) shall be effective once such regulatory approval(s) has been received.

Notwithstanding the foregoing, amendments required because of legislative, regulatory or governmental agency requirements do not require the consent of Provider or ACOH and shall be effective immediately on the effective date thereof. This Agreement remains subject to the approval of the State of Ohio, and may be amended by ACOH to comply with any requirements of the State of Ohio. Provider acknowledges that all Agency requirements, as may be amended from time to time, are incorporated to this Agreement.

10.4 This Agreement shall be deemed to have been made and shall be construed and interpreted in accordance with the laws of the State of Ohio.

10.5 This Agreement and its exhibits, appendices, schedules, addenda or other attachments constitute the entire understanding and agreement between the parties concerning the subject matter hereof. This Agreement supersedes all prior written or oral agreements or understandings existing between the parties concerning the subject matter hereof including, but not limited to, any such agreement which may have been previously executed between Provider and ACOH or any of its Affiliates relating to the provision of Covered Services under the Program. In the event of a conflict between the terms of this Agreement and the Provider Manual, the terms of the later document shall control.

10.6 Written notices to be given hereunder shall be sent by Certified Mail, Return Receipt Requested, or by an overnight delivery service which provides a written receipt evidencing delivery to the address set forth by the party, or by confirmed facsimile followed by written notice through the U.S. postal service. All notices called for hereunder shall be effective upon receipt.

If to Provider:

With a copy to:

If to AmeriHealth Caritas Ohio, Inc.:

With a copy to: General Counsel
AmeriHealth Caritas
200 Stevens Drive
Philadelphia, PA 19113

10.7 Both parties agree that there shall be no discrimination in the performance of this Agreement against any patient or other person as the result of that individual's race, color, religion, gender, sexual orientation, handicap, age, national origin, source of payment, or any other basis prohibited by law.

10.8 The failure of any of the parties to insist upon strict performance of any of the terms of this Agreement shall not be deemed a waiver of any of their respective rights or remedies, and shall not be deemed a waiver of any subsequent breach or default in any of the terms contained in this Agreement.

10.9 In the event that any provision under this Agreement is declared null or void, for any reason, the remaining provisions of this Agreement shall remain in full force and effect.

10.10 The parties will use reasonable care and due diligence in performing this Agreement. Provider will be solely responsible for the services provided under this Agreement.

10.11 All captions contained in this Agreement are solely for the convenience of the parties hereto and shall not be deemed part of the content of this Agreement.

10.12 All terms used in this Agreement are deemed to refer to the masculine, feminine, neuter, singular or plural as the content may require.

10.13 Non-Discrimination. Provider shall comply with (i) Title VI of the Civil Rights Act of 1964 and the rules, regulations, and order; (ii) the Rehabilitation Act of 1973 and the rules, regulations, and orders thereunder; (iii) the Americans With Disabilities Act of 1990 and the rules, regulations, and orders thereunder; and (iv) any and all applicable laws, rules and regulations prohibiting discriminatory practices. Furthermore, in accordance with Title VI of the Civil Rights Act of 1964 and the rules, regulations and orders thereunder, Provider shall take adequate steps to ensure that Members with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under this Agreement (see 42 U.S.C. 2000d et seq. and 45 C.F.R. Part 80, 2001 as amended).

10.14 No Offshore Contracting. No Covered Services under this Agreement may be performed outside of the United States without ACOH's prior written consent. In addition, Provider will not hire any individual to perform any services under this Agreement if that individual is required to have a work visa approved by the U.S. Department of Homeland Security and such individual has not met this requirement.

[SIGNATURES ON FOLLOWING PAGE; REMAINDER OF PAGE INTENTIONALLY BLANK]

IN WITNESS WHEREOF, and intending to be legally bound hereby, the parties hereto, each by its officers duly authorized, hereby affix their hands as of the date written below.

ANCILLARY PROVIDER	**AmeriHealth Caritas Ohio, Inc.**
_____ Print Name _____ Signature _____ Title _____ Address _____ National Provider ID Number _____ _____ Medicaid ID Number Medicare ID Number _____ Tax ID Number _____ Date **Check and initial** if Assignment of Payment Not **Applicable: ☐ Provider Initials _____** **Assignment of Payment (*applicable to Group Practitioner only*): By signing below, Provider hereby assigns and transfers all Provider's right to and interest in compensation payable by ACOH pursuant to this Agreement to the party identified below, and Provider therefore directs ACOH to pay such compensation to said party:** _____ Provider Signature _____ Name of Group _____ Address _____ Group Tax ID Number	_____ Name _____ Signature _____ Title _____ Date **Effective Date of Agreement: _____** [To be completed by AmeriHealth Caritas Ohio, Inc.]

APPENDIX A

ANCILLARY SERVICES PROVIDER

COVERED SERVICES

Provider shall furnish the following Covered Services to Members:

Provider's compensation for Covered Services is set forth in **Appendix A-1.**

APPENDIX A-1

ANCILLARY SERVICES PROVIDER

COVERED SERVICES COMPENSATION SCHEDULE

Commencing on the Effective Date, ACOH will compensate Provider for Covered Services rendered by Provider to Members in accordance with the terms of this Agreement at a rate of **[_____]**, less applicable co-insurance and deductibles. Payments will be made in accordance with Ohio Medicaid payment policies, and with retroactive effective dates as necessary to coincide with the effective dates of changes made by the Agency to its fee schedule. In no event will ACOH's payment exceed Provider's charges.

APPENDIX B

ANCILLARY SERVICES PROVIDER

ACOH AFFILIATES

No ACOH Affiliates are covered by this Agreement.

APPENDIX C

ANCILLARY SERVICES PROVIDER

PROVIDERS AND SERVICE LOCATIONS COVERED BY AGREEMENT

PROVIDER AND SERVICE LOCATION

_____._
Name

_____
Address

_____
City, State, Zip

_____
Phone Number

PROVIDER AND SERVICE LOCATION

_____
Name

_____
Address

_____
City, State, Zip

_____
Phone Number

PROVIDER AND SERVICE LOCATION

_____
Name

_____
Address

_____
City, State, Zip

_____
Phone Number

Schedule 9-1
Federal Requirements – Medicaid and Medicaid Managed Care
(Rev. 7/1/17)

1. No payment will be made to Provider for provider-preventable conditions or health care-acquired conditions. For purposes hereof:

    a. **Health care-acquired condition** ("HAC") means a condition occurring in any inpatient hospital setting, identified as a HAC by the Secretary of the U.S. Department of Health and Human Services ("HHS") under section 1886(d)(4)(D)(iv) of the Social Security Act (the "Act") for purposes of the Medicare program identified in the State plan as described in section 1886(d)(4)(D)(ii) and (iv) of the Act, other than deep vein thrombosis/pulmonary embolism as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients.

    b. **Other provider-preventable condition** means a condition occurring in any health care setting that meets the following criteria: (i) is identified in the Ohio Medicaid plan; (ii) has been found by the Ohio, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines (iii) has a negative consequence for the Member; (iv) is auditable; and (v) includes, at a minimum, wrong surgical or other invasive procedure performed on a patient, surgical or other invasive procedure performed on the wrong body part, or surgical or other invasive procedure performed on the wrong patient.

    c. **Provider-preventable condition** ("PPC") means a condition that meets the definition of "health care-acquired condition" or an "other provider-preventable condition."

    No reduction in payment will be made for a PPC when the condition existed prior to the initiative of treatment for that patient by Provider. Provider shall identify PPCs when submitting claims for payment or, if no claim will be submitted, if Medicaid payment would otherwise be available for the course of treatment in which the PPC occurred, or as otherwise required by the State. **42 CFR §§438.3(g), 434.6(a)(12) and 447.26.**

2. Physician Incentives. Provider shall disclose to ACOH annually any Physician Incentive Plan (PIP) or risk arrangements Provider may have with physicians, either within Provider's group practice or other physicians not associated with Provider's group practice, even if there is no substantial financial risk between ACOH and the physician or physician group. The term "substantial financial risk" means a financial risk set at greater than twenty-five percent (25%) of potential payments for Covered Services, regardless of the frequency of assessment (i.e., collection) or distribution of payments. The term "potential payments" means simply the maximum anticipated total payments that the physician or physician group could receive if the use or cost of referral services were significantly low. **42 CFR §§438.3(i), 422.208, 422.210**.

3. Provider Discrimination Prohibited. ACOH may not, with respect to Provider participation, compensation or indemnification under this Agreement, discriminate against Provider to the extent that the Provider is acting within the scope of his, her or its license or certification under applicable State law, solely on the basis of that license or certification. Without limiting the foregoing, ACOH shall not discriminate against Provider for serving high-risk populations or specializing in conditions that require costly treatment. Nothing herein shall be construed to: (i) require ACOH to contract with Provider if not necessary to meet the needs of Members; (ii) preclude ACOH from using different reimbursement amounts for different specialties or for

different practitioners in the same specialty; or (iii) preclude ACOH from establishing measures that are designed to maintain quality of services and control costs and are consistent with ACOH's responsibilities to Members. **42 CFR §§438.12, 438.214(c)**.

4. Member Rights. Provider shall adhere to all applicable Federal and State laws that pertain to Member rights, and shall take such rights into account when furnishing services to Members. **42 CFR §438.100(a)(2)**.

5. Provider-Member Communications. Nothing in this Agreement shall be construed to prohibit, restrict or impede Provider's ability to freely and openly discuss with Members, within the Provider's lawful scope of practice, all available treatment options and any information the Member may need in order to decide among all relevant treatment options, including but not limited to the risks, benefits and consequences of treatment or non-treatment, regardless of whether the services may be considered Covered Services in accordance with this Agreement. Further, nothing in this Agreement shall be construed to prohibit, restrict or impede Provider from discussing Medically Necessary care and advising or advocating appropriate medical care with or on behalf of a Member, including: information regarding the nature of treatment options, risks of treatment, alternative treatments or the availability of alternative therapies, consultation or tests that may be self-administered, and the Member's right to participate in decisions regarding his or her care, including the right to refuse treatment and to express preferences about future treatment decisions. **42 CFR §438.102(a)**.

6. Member Hold Harmless. Provider shall accept the final payment made by ACOH as payment in full for Covered Services provided pursuant to this Agreement. Provider agrees that in no event, including, but not limited to, nonpayment by the Agency to ACOH, nonpayment by ACOH to Provider, the insolvency of ACOH, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, solicit or accept any surety or guarantee of payment, or have any recourse against Members or persons other than ACOH acting on their behalf (including parent(s), guardian, spouse or any other person legally, or potentially legally, responsible person of the Member) for Covered Services listed in this Agreement. This provision shall not prohibit collection of supplemental charges or co-payments on ACOH's behalf made in accordance with terms of an enrollment agreement between ACOH and Members.

   Provider further agrees that:

   a. this hold harmless provision shall survive the termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of Members; and that

   b. this hold harmless provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and Members or persons acting on their behalf.

   42 CFR §§438.106, 447.15.

7. Coverage and Payment for Emergency Services. ACOH shall cover and pay for Emergency Services rendered by Provider and obtained when a Member had an Emergency Medical Condition, or when a representative of ACOH has instructed the Member to seek Emergency Services. **42 CFR §438.114(c)(1)(ii)**.

8. Timely Access. Provider shall meet Agency standards for timely access to care and services, taking into account the urgency of the need for services. Provider shall offer hours of operation to Members that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if Provider serves only Medicaid enrollees. Provider services shall be available 24 hours a day, 7 days a week, when medically necessary. Provider shall provide physical access, reasonable accommodations, and accessible equipment for Members with physical or mental disabilities. **42 CFR §438.206(c)**.

9. Excluded Providers. Pursuant to **42 CFR §438.214(d)**, ACOH may not employ or contract with providers, or have a relationship with a person or entity that is excluded from participation in Federal health care programs under either Section 1128 or 1128A of the Act. ACOH may not knowingly have a Prohibited Relationship (defined hereinafter) with the following: (a) an entity or individual that is debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549; or (b) an individual or entity who is an affiliate, as defined in the Federal Acquisition Regulation at 48 CFR §2.101 of a person described in the **subparagraph 9(a)**. For purposes of this **paragraph 9**, "Prohibited Relationship" includes a subcontractor of ACOH and a network provider or person with an employment, consulting or other arrangement with ACOH for the provision of items or services that are significant and material to ACOH's obligations under the Agency Contract. Provider shall comply with the disclosure, screening and enrollment requirements of **42 C.F.R. Part 455, Subparts B and E** and, upon reasonable request, provide such information to ACOH in accordance with the requirements specified therein. **42 CFR §§438.608(b), 438.610**

   Provider represents and warrants that neither it, nor any of its contractors or employees who will furnish goods or services under the Agreement, directors or officers, or any person with an ownership interest in Provider of five percent (5%) or more, is or ever has been: (i) debarred, suspended or excluded from participation in Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP) or any other Federal health care program; (ii) convicted of a criminal offense related to the delivery of items or services under the Medicare or Medicaid program; (iii) had any disciplinary action taken against any professional license or certification held in any state or U.S. territory, including disciplinary action, board consent order, suspension, revocation, or voluntary surrender of a license or certification; or (iv) debarred or suspended from participation in procurement or non-procurement activities by any federal agency (collectively, "Sanctioned Persons"). Provider shall screen all employees and contractors who will furnish goods or services under this Agreement to determine whether they have been excluded from participation in any Federal health care program, by searching applicable Federal and State databases (including but not limited to the OIG's LEIE and the NPDB) upon initial employment or engagement of or contracting with a contractor, employee, director or officer, and on a monthly basis thereafter.

   Provider shall immediately notify ACOH upon knowledge by Provider that any of its contractors or employees who furnish goods or services under the Agreement, directors, officers or owners has become a Sanctioned Person, or is under any type of investigation which may result in their becoming a Sanctioned Person. In the event that Subcontractor cannot provide reasonably satisfactory assurance to ACOH that a Sanctioned Person will not receive payment from ACOH under this Agreement, ACOH may immediately

terminate this Agreement. ACOH reserves the right to recover all amounts paid by ACOH for items or services furnished by a Sanctioned Person. Further, and without limiting Provider's indemnification obligations set forth elsewhere in this Agreement, to the extent penalties, fines or sanctions are assessed against ACOH as a result of Provider's having a relationship with a Sanctioned Person, Provider shall be responsible for the immediate payment of such penalties, fines or sanctions. In the event such payment is not made in a timely manner to ACOH, ACOH shall have the right to offset claims payments to Provider by the amount owed by Provider to ACOH.

10. State and Federal Regulator Access. Provider acknowledges that the U.S. Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS), Office of the Inspector General, the Comptroller General, the Agency, and their designees may at any time inspect and audit any records or documents of Provider pertinent to this Agreement, including those pertaining to the quality, appropriateness and timeliness of services; and may at any time inspect the premises, physical facilities and equipment where Medicaid-related activities or work is conducted. The right to audit under this paragraph exists for ten (10) years from the final date of the Agency Contract or from the completion of any audit, whichever is later. **42 CFR §§434.6(a)(5), 438.3(h)**.

11. Provider shall safeguard information about Members as required by Part 431, Subpart F of 42 CFR. **42 CFR §434.6(a)(8)**.

12. Any permitted subcontracts entered into by Provider in order to carry out its obligations under this Agreement must be in writing and fulfill the requirements of 42 CFR Part 438 that are appropriate to the service or activity delegated under the subcontract, in accordance with 42 CFR **§438.230**. **42 CFR §§434.6(a)(11), (b), 438.3(k)**.

13. Provider must retain, as applicable, the following information for a period of not less than ten (10) years:

    a. Member grievance and appeal records in 42 CFR §438.416;

    b. Base data used to determine capitation rates, in 42 CFR §438.5(c);

    c. MLR reports in 42 CFR §438.8(k); and

    d. The data, information and documentation specified in 42 CFR §§438.604 , 438.606, 438.608 and 438.610**.**

    42 CFR §438.3(u).

14. Provider shall maintain and share, as appropriate, an enrollee health record in accordance with professional standards. **42 CFR §438.208(b)(5)**.

15. To the extent Provider conducts UM activities on behalf of ACOH, Provider's compensation under this Agreement shall not be structured so as to provide incentives for Provider to deny, limit or discontinue medically necessary services to any Member. **42 CFR §438.210(e)**.

16. Delegation. The following provisions shall apply to the extent any of ACOH's activities or obligations under the Agency Contract are delegated to Provider:

a. The delegated activities and related reporting responsibilities will be specified in the Agreement or in a separate delegation contract;

b. Provider agrees to perform the delegated activities and reporting responsibilities in company with ACOH's Agency Contract obligations;

c. ACOH may impose corrective actions, up to and including revocation of the delegated activities or obligations, in instances where the Agency or ACOH determine that Provider has not performed satisfactorily.

d. To the extent Provider is delegated responsibilities for coverage of services and payment of claims, Provider shall implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste and abuse that meet the requirements of **42 CFR §438.608(a)**.

Notwithstanding the foregoing, ACOH maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of the Agency Contract. **42 CFR §438.230(b)(c)**.

17. Provider agrees to comply with all applicable Medicaid laws, regulations (including applicable sub-regulatory guidance) and Agency Contract provisions. Provider agrees that:

    a. The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate and inspect any books, records, contracts, computer or other electronic system of Provider, or of any subcontractors, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Agency Contract.

    b. Provider will make available, for purposes of an audit, evaluation or inspection under subparagraph 17(a), its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to ACOH's Members.

    c. The right to audit under subparagraph 17(a) will exist through ten (10) years from the final date of the Agency Contract or from the date of completion of any audit, whichever is later.

    d. If the State, CMS or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the state, CMS or the HHS Inspector General may inspect, evaluate and audit Provider at any time.

    42 CFR §438.230(c)(2), (3)

18. ACOH may terminate this Agreement immediately upon notification from the Agency that Provider cannot be enrolled in the State Medicaid program, or if Provider has not enrolled in the State Medicaid Program within 120 days of the effective date of this Agreement. **42 CFR §438.602(b)(2)**.

Schedule 9-2
Ohio Medicaid Addendum

[Attach ODM AmeriHealth Caritas Ohio, Inc. Medicaid Addendum]