File

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Myers / Hamilton / Singleton	11-20-09

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 100234	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR _____	[ ] Prepare reply for appropriate signature DATE DUE _____
	[ ] FOIA DATE DUE _____
	[X] Necessary Action

	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.		
2.		
3.		
4.		

Brenda consider this closed

Brenda / Jan –
This is our response – please close this one out
Thx
Fel

From: Felicity Myers
To: jclark@spartnership.com
Date: 11/30/2009 5:47 PM
Subject: FOIA request

Mr Clark,
As I indicated to you on the phone, the dental services are carved-out of the capitated rate for Healthy Connections Kids and are paid through Fee for Service (FFS). Therefore there are no "active contracts with managed care organizations (MCOs) which provide dental services to beneficiaries of Healthy Connection Kids".
As I also indicated the dental services are carved out of our Medicaid Managed Care program as well and paid for through FFS, but some plans do choose to offer adult dental services as an enhanced service- these are not calculated into the capitated rates.
You can see which plans offer adult dental services by going to scchoices.com and go to brochures and charts and view plans by county.
This should satisfy your FOIA request, but please let me know if you need anything else.
Felicity Myers

Felicity Costin Myers, Ph.D.
Deputy Director of Medical Services
Department of Health and Human Services
myersfc@scdhhs.gov
(803) 898-2803

CC: Deirdra Singleton; Jan Polatty; Jeff Stensland

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Myers / Hamilton / Singleton	11-20-09

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 060234	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR cc: Nikole	[ ] Prepare reply for appropriate signature DATE DUE _____ [ ] FOIA DATE DUE _____ [X] Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			
2.			
3.			
4.			

JAN - NEED COPIES FOR DEIRDRA + NIKOLE + BEV

I meet w/ them Monday

LOG INTO ME + BEV + Deirdra

See if I can get a mtg w/ Bev Tim H. + Barbara Smith + Nikole tomorrow.

HCA

Hospital Corporation of America

South Atlantic Division
900 Island Park Drive, Suite 202A
Daniel Island, SC 29492

Phone 843 847-4010
Fax 843 216-5984

November 16, 2009

Felicity Costin Myers, Ph.D
Deputy Director of Medical Services
Department of Health & Human Services
1801 Main Street
11th Floor
Columbia, SC 29201

Re: Approval of Select Health's Participation Agreement with South Atlantic Division, Inc.

Dear Ms. Myers:

The South Atlantic Division, Inc. ("South Atlantic"), an HCA affiliate, which contracts on behalf of HCA Hospitals in South Carolina, specifically Trident Regional Medical Center, Colleton Medical Center, Grand Strand Regional Medical Center as well as other HCA facilities (the "HCA Facilities"), has been in contract negotiations with Select Health of South Carolina, Inc. ("Select Health"). The HCA Facilities have participated in Select Health's Medicaid Managed Care Program for a number of years. Recently, Select Health and South Atlantic entered into a renegotiation of their existing agreement. Select Health and South Atlantic reached a satisfactory agreement, which attorneys for both parties believed complied with South Carolina law, the South Carolina Department of Health and Human Services ("DHHS") April 2008 Model Contract for managed care organizations (the "Model Contract") and the DHHS April, 2008 Policy and Procedure Guide for Managed Care Organizations, as posted on its website (the "Guide").

Select Health presented to DHHS a Participation Agreement with a regulatory addendum designed to satisfy the then current DHHS model contract requirements the Guide. Our attorneys believe that this format has been approved by DHHS in the recent past. DHHS, however, rejected the Participation Agreement and Regulatory Addendum and insisted that the parties enter into an agreement with no regulatory addendum. In an effort to comply with DHHS's request, the provisions of the regulatory addendum were incorporated into the base agreement, which was again sent to DHHS for approval. Once again, DHHS disapproved the agreement.

The basis for the second rejection is set forth in the attached document, which we understand was prepared by Tim Hartnett with assistance from David Smith. (See Exhibit "A"). DHHS's objections to the contract fall into several categories:

Timeline SCDHHS and the South Atlantic Division contract:

September 23, 2009- Peggy Vickery send South Atlantic Division contract to David Smith for review. David forwards the contract to Tim Hartnett on the same day.

September 28, 2009-Tim Hartnett sends Peggy Vickery the review of the reasons for denying the South Atlantic Division contract.

October 7th, Lisa Thomas leaves a voice message for David Smith asking him to return her call concerning the South Atlantic Division Contract.

October 8, 2009 David Smith and Tim Hartnett return the call to Lisa Thomas left her a message informing her that any questions she has about the denial should be addressed to Peggy Vickery at Select as the contract is between South Atlantic Division and Select Health. The only role SCDHHS play is to review the submitted contract for compliance.

October 9, 2009 Callie Campbell calls Jennifer Campbell requesting information on the South Atlantic Contract denial. Jennifer forwards the call to Larry Fernandez, Tim Hartnett, Jim Bradford, Jennifer Campbell and Jim Bradford call Callie Campbell. Ms. Campbell told us she worked for Haynsworth Sinkler and Boyd but would not tell us who her client was or how she had access to confidential contract amendments when the information was not available to the general public.

— Haynesworth, Sinkler + Boyd

June/July conversation w/ Peggy Vickery
- provider wanted to use own - Tim indicated needed to use Select boilerplate
- notify has case from Select in terms of issues.
- Section 5
- using commercial language versus Medicaid language
- we typically communicate directly w/ plan only never w/ hospital only - occasionally w/ plan + hospital
- the attached contract only covers to Medicaid, not HCIC
- we have different requirements for a contracts

- The first category of changes involves negotiated changes between Select Health and South Atlantic regarding Select Health's policies and procedures. For example, the parties had agreed that Select Health's policies and procedures were not incorporated into the Agreement. (The parties have agreed that they will comply with all DHHS policies and procedures and incorporated DHHS policies where required.) Plans desire to unilaterally amend their policies and procedures and often do so in a manner that is adverse to the interest of the provider. The proposed deletion of these provisions interferes unreasonably with the relationship between Select Health and South Atlantic, and we request reconsideration of DHHS's position in this regard.

- Second, DHHS rejected many provisions because the syntax or order of words of a sentence did not exactly match the syntax or order of words contained in the model agreement. In addition, the parties had added language, consistent with the Guide and federal law that were not in the Model Contract. DHHS required the additional language to be deleted. South Atlantic and Select Health will agree to make those changes and they are set forth in the attached redlined agreement. (See Exhibit "B"). South Atlantic, however, requests that DHHS reconsider its rejection of the language related to the definitions of "Emergency Medical Condition" and "Medically Necessary." The additional language regarding the application of the definition of Emergency Medical Condition to pregnant women is designed to comply with the Emergency Medical Treatment and Active Labor Act ("EMTALA") and Section 4.3 of the Model Contract. The addition of this language is not prohibited by state or federal law, the Guide or the Model Contract. Rather, it is designed to clarify Select Health's obligations to cover Emergency Services provided to this vulnerable population. Further the language ensures that the determination of whether the Emergency Medical Condition exists remains with the treating physician. This is consistent with Section 4.3 of the Model Contract and EMTALA and better protects the Member. Select Health agreed with this language. We are unable to discern why DHHS would require the language to be deleted as it is lawful and consistent with the Guide.

EMTALA

- The third category of changes involves the deletion of any provision that permitted the HCA Facilities to collect any Member co-payment or to charge the member for Non-Covered Services. South Atlantic appreciates DHHS's efforts to protect its Members, and is willing to accept DHHS's changes with regard to the definition of Covered Services. However, many of the other requested changes would limit South Atlantic's rights, which are clearly protected by law. The Select Health Model Agreement, the Guide and South Carolina state law all permit a healthcare provider to collect non-covered expenses from a member of the Medicaid Managed Care Program. S.C. Code Ann. §38-33-130; Model Contract § 13.27. Further, federal law permits, as does the Model Contract,

copay

limited co-payments for adult members over the age of 19. Model Contract Section 2.3. On the other hand, DHHS insists that Select Health and South Atlantic delete the Section 5.8.2, which would have permitted the HCA Facilities to waive a co-payment, for example, under its charitable care policies, a provision that benefits Members.

It is our contention that DHHS's insistence that the parties remove these provisions unreasonably interferes with Select Health's and South Atlantic's negotiated agreement. Given that Select Health has accepted a risk-based contract with DHHS, we question DHHS's reasoning for requiring such deletions to the agreement, when the underlying provisions are clearly permitted by law and not contrary to the Guide or the Model Contract. DHHS has provided us with no reasoning or basis for its disapproval of these provisions. While, at this time, Select Health's plan design does not require Member copayments (even though permitted by DHHS), it may do so in the future, with DHHS approval. Because the parties intend this Agreement to survive Plan changes, we respectfully request the language, as revised, be approved.

- Finally, in a number of places, Mr. Hartnett was unable to locate provisions required by the Model Contract that are, in fact, included in both the first and second agreements. Similarly, Mr. Hartnett has requested that the references to the Guide be changed to reflect an October 1, 2009 update. We would note this update was not posted or publicly available on the DHHS website as late as October 7, 2009. DHHS subsequently posted an "informational" draft on the website, with the disclaimer that it is pending CMS approval. The proposed agreement clearly acknowledges that DHHS policies and procedures may be updated from time to time and incorporates any such updates by reference. Accordingly, we believe these requested changes are unnecessary and may be confusing if the final update is never posted, posted with a different date, or ultimately not approved by CMS.

In an effort to work through these issues with DHHS, our attorney called Mr. Smith who had forwarded DHHS's comments to Ms. Peggy Vickery with Select Health, who in turn forwarded them to South Atlantic. Mr. Smith and Mr. Hartnett returned our attorney's call, but were not willing to discuss DHHS's comments requesting that any changes be communicated through Select Health. Because Select Health has interests that are counter to the provider, it is inappropriate for Select Health to independently negotiate changes to the Agreement that will potentially impact South Atlantic in an adverse manner. DHHS's unwillingness to discuss its requested changes to the Agreement gives the Plans an unfair competitive advantage over the providers at a time when Select Health's denial rate is running at approximately 10%. After having negotiated a contract with Select Health, South Atlantic's efforts to move forward to address and discuss DHHS's comments are completely stalled by DHHS's unwillingness to discuss its position and reasonably negotiate the necessary changes.

Thank you for agreeing to meet with me on Monday, November 23rd. I look forward to meeting you and working together to resolve these matters.

Sincerely,

Rodney Van Pelt

Rodney Van Pelt
Chief Financial Officer
South Atlantic Division

~~09/03/09 Redline from Facility~~
~~Blended Document: Blends Regulatory Requirements into Base Agreement~~**MANAGED MEDICAID**
FACILITY PARTICIPATION AGREEMENT

This Facility Participation Agreement ("**Agreement**") is executed by and between **Select Health of South Carolina, Inc.** ("**Plan**") and **South Atlantic Division, Inc.** as disclosed agent (the "**Disclosed Agent**") on behalf of those facilities identified in **Attachment C**, which is attached hereto and made a part hereof (each referred to herein individually as "**Facility**" whether or not licensed as a general acute care facility), and is effective as of _____, 2009 (the "Effective Date").

SECTION 1

RECITALS

1.1 Plan is a South Carolina licensed Health Maintenance Organization ("HMO") that is approved and operated as a Medicaid Managed Care Entity as defined at Section 1932 of the Social Security Act and applicable regulations.

1.2 Plan has contracted to assist the South Carolina Department of Health and Human Services ("**SCDHHS**") in the purchase and provision of healthcare services under the South Carolina Medicaid Managed Care Organization ("MCO") Program, and seeks to delegate to Facility the provision of healthcare services included in the South Carolina State Medicaid Plan ("**Covered Services**") to Medicaid MCO Program members.

1.3 Facility is licensed and duly authorized in the State of South Carolina to provide healthcare services and seeks to provide Covered Services to Medicaid MCO Program members in exchange for payment by the Plan for services rendered.

1.4 Plan and Facility desire to enter into this Agreement setting forth the rights and responsibilities of the parties with respect to the provision of Covered Services to Medicaid MCO Program members and in accordance with the Medicaid MCO Contract, as applicable to Plan, any applicable State Medicaid Agency Manuals applicable to Plan or Facility, and all applicable State and federal laws and regulations as applicable to this Agreement.

SECTION 2

DEFINITIONS

2.1 **Affiliate**. An entity controlled by, controlling, or under common control with another entity including, but not limited to, through ownership of stock, joint venture, membership interest, or a management contract. For purposes of this definition, "control" of an entity means direct or indirect ownership of a majority of the entity.

2.2 **Billed Charges.** The total charges for services rendered by Facility as set forth in the Facility's internally established charge master in effect on the date the services are rendered,

considered Facility's usual and customary charges; such charges are not dependent upon a governmental or payor fee schedule.

2.3 **Clean Claim.** A Claim that can be processed without obtaining additional information from the provider of the service or from a third party.

2.4 **Claim.** A paper or electronic billing instrument that consists of a complete UB-~~92~~04 or CMS ~~1450,~~1500, as applicable, data set, or their respective successor forms, with entries stated as mandatory by the National Uniform Billing Committee, and with respect to electronic claim forms, completed in the format and with the data content and data conditions specified in HIPAA.

2.5 **CMS.** The federal Centers for Medicare and Medicaid Services (formerly known as the Health Care Financing Administration).

2.6 **Covered Services.** Services included in the South Carolina State Medicaid Plan and as set forth in Attachment A hereto.

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

~~(a) Serious jeopardy to the health of a patient, including a pregnant woman or a fetus.~~

~~(b) Serious impairment to bodily functions.~~

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

With respect to pregnant women, an emergency medical includes, but not limited to, condition when there is:

(a) Inadequate time to effect safe transfer to another facility prior to delivery.

(b) Transfer may pose a threat to the health and safety of the patient or fetus.

(c) Evidence of onset of uterine contractions or rupture of the membranes.

2.8 **Emergency Services**. Covered inpatient and outpatient services that are as follows: (1) furnished by a provider that is qualified to furnish these services; and (2) needed to evaluate or stabilize an Emergency Medical Condition, as determined by the emergency physician or provider actually treating the Member.

2.9 **EPSDT.** An Early and Periodic Screening, Diagnosis and Treatment Program mandated by Title XIX of the Social Security Act.

2.10 **Federally Qualified Health Center ("FQHC").** A South Carolina licensed health center certified by the CMS that receives Public Health Services grants. A FQHC is eligible for state defined cost based reimbursement from the Medicaid fee-for-service program. A FQHC provides a wide range of primary care and enhanced services in a medically underserved area.

2.11 **HIPAA.** Health Insurance Portability and Accountability Act of 1996, and the rules and regulations promulgated thereunder, each as may be amended from time to time.

2.12 **Medicaid MCO Contract.** The contract between Plan and SCDHHS.

2.13 **Managed Medicaid Plan.** A health benefit design or product, offered and issued by Plan pursuant to the Medicaid MCO Contract, that contains the terms and conditions of a Member's coverage, under which the Member and Plan are obligated to pay for Covered Services and under which Facility is a Participating Provider pursuant to the terms of this Agreement.

2.14 **Medicaid MCO Program.** The South Carolina Medicaid managed care program regulated, operated and administered by CMS~~,~~ or SCDHHS ~~and/or an HIO~~, pursuant to Sections 1902(a)(4), 1903(m), 1905(t), and 1932 of the Social Security Act and for which an **Attachment A** is incorporated into this Agreement setting forth the Facility's reimbursement for the Program.

2.15 **Medically Necessary.** Those medical services which: (i) are essential to prevent, diagnose, prevent the worsening of, alleviate, correct or cure medical conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or aggravate a handicap, or result in illness or infirmity of a Medicaid MCO Program member as directed by the treating physician; (ii) are provided at an appropriate facility and at the appropriate level of care for the treatment of Medicaid MCO Program member's medical condition; and, (iii) are provided in accordance with generally accepted standards of medical practice.

Plan agrees, by law, that what constitutes medically necessary services (i) may be no more restrictive than that used in the Medicaid MCO Program as indicated in State statutes and regulations and other State policy and procedures and (ii) must address the extent to which the Plan is responsible for covering services related to the following: (a) the prevention, diagnosis, and treatment of health impairments; (b) the ability to achieve age-appropriate growth and development; and (c) the ability to attain, maintain, or regain functional capacity.

2.16 **Member.** An individual who is an eligible Medicaid MCO Program beneficiary and who is voluntarily enrolled as a Plan member in accordance with requirements of the applicable Medicaid MCO Program.

2.17 **Member Expenses.** Any amounts that are the Member's responsibility to pay a health care provider or professional pursuant to the Member's Medicaid MCO Plan, including without limitation co-payments, ~~coinsurance, deductibles, other cost-share amounts, and amounts for Non-Covered Services~~if permitted by the Managed Medicaid Plan.

2.18 **Non-Covered Services.** Services not covered under the Title XIX SC State Medicaid Plan ~~and services that are not Covered Services a defined herein, including, but not limited to,~~

~~those services denied as not Medically Necessary, services de-certified and those services not authorized~~.

2.19 **Participating Facility.** A facility which has entered into a direct written agreement with Plan to provide Covered Services.

2.20 **Participating Provider.** A health care professional, provider or facility, including but not limited to a physician, home health agency, hospital, ambulatory surgery center, laboratory or other professional, facility, supplier, or vendor that has entered into a written agreement with Plan, directly or through one or more other entities, to provide Covered Services to all or some Members.

2.21 **Post-Stabilization Services.** Covered Services, including emergency admissions related to an Emergency Medical Condition, that are provided after a Member is stabilized in order to maintain the stabilized condition, or improve or resolve the Member's condition.

2.22 **Primary Care Provider or PCP.** The provider who serves as the entry point into the health care system for the Member. The PCP is responsible for including, but not limited to providing primary care, coordinating and monitoring referrals to specialist care, authorizing hospital Covered Services, and maintaining the continuity of care.

2.23 **Receipt.** The initial receipt of a Claim submitted by Facility for services rendered to Members, i.e., the initial receipt of a Claim by Plan. There shall be a rebuttable presumption that a Claim has been received by the party to whom it was transmitted within (i) three (3) business days following the date Facility placed the Claim in the United States mail for Claims submitted by paper, or (ii) the date verified by the 277 transaction set A-2 status code for Claims submitted electronically. The date of the receipt of the Claim is the date the Plan receives the Claim, as indicated by the date stamped on the Claim. The date of payment is the date of the check or other form of payment.

2.24 **Regulatory Requirements**. Any requirements imposed by applicable federal or state rules and regulations imposed pursuant to a Medicaid MCO Contract, or in connection with the operation of the Medicaid MCO Program which are considered mandatory on Facilities and which can not be modified by contract.

2.25 **Service Area**. The geographic area in which eligible Medicaid MCO Program members may be accepted for enrollment into the Plan. The Service Area must be approved by the South Carolina Department of Insurance ("SCDOI").

2.26 **State**. The state of South Carolina.

2.27 **State Agency**. The South Carolina Department of Health and Human Services and any instrumentality thereof.

2.28 **State Medicaid Agency Materials**. SCDHHS's policy and procedure manual applicable to the South Carolina Medicaid MCO Program and available in writing or electronically on the SCDHHS website, including (i) the South Carolina Policy and Procedure Guide for Managed Care Organization effective April 2008, as may be updated from time to time

(the "Guide") and (ii) the model contract between SCDHHS and 2008 Managed Care Providers dated as of July 1, 2009 (the "Model Contract"). SCDHHS "policies" are the general principles by which SCDHHS is guided in its management of the Medicaid MCO program, as further defined by SCDHHS promulgations and by state federal rules and regulations.

SECTION 3

SCOPE OF AGREEMENT

3.1 **Accessibility.** This Agreement applies to those Facilities set forth in **Attachment C** and the Managed Medicaid Plans set forth in **Attachment B**. During the term of this Agreement, Facility agrees to be a Participating Provider, and Plan agrees to pay Facility for Covered Services provided pursuant to the terms of this Agreement at the rates set forth in **Attachment A** which rates shall apply to inpatient discharge dates and outpatient service dates which occur on or following the Effective Date. The parties agree that this Agreement is a full service agreement allowing for access to and payment for both inpatient and outpatient care, services and technology available at and offered by Facility for all Members on the same basis and through the same referral and approval process as Plan uses with other Participating Providers.

3.2 **Credentialing**. Plan shall credential Facility and all Participating Providers providing services hereunder using nationally recognized criteria. Plan will work diligently to credential physicians who are on Facility's medical staff (provided such physicians meet the credentialing criteria referenced above), and new Facilities that become Participating Providers during the term of this Agreement.

3.3 **Physician Access.** Plan will not in any way discourage Members or Participating Providers from being able to access Facility for any service that is performed or made available by Facility.

3.4 **Consistent Criteria.** Plan, including any third party acting on Plan's behalf, will not disadvantage Facility in relation to other Participating Facilities or Participating Providers through the use of preferential Member Expenses. Plan and any third party acting on Plan's behalf, will apply its criteria authorizing services and approving referrals consistently to all Participating Providers.

3.5 **Proprietary Rate Information.** Plan agrees not to sell, broker or share rate information or provide it to any third party except as required by any governmental agency or as otherwise required by law.

3.6 **Addition of New Medicaid MCO Plans.** Notwithstanding anything to the contrary in this Agreement, the parties must mutually agree in writing to the addition of new or modified Medicaid MCO Plan product offerings and applicable reimbursement rates associated with these new product offerings.

SECTION 4

DUTIES OF FACILITY AND PLAN

4.1 **Identification Cards.** Plan shall provide Members with a unique identification card. Plan will provide Facility with specimen identification cards used by Members for Managed Medicaid Plans covered under this Agreement to enable Facility to initially verify a patient's access to the Plan discount. A listing of all Participating Providers, including without limitation Facility, will be made available by Plan to Members. Members must present their identification cards at the time of registration or receipt of services upon each inpatient or outpatient encounter. The parties agree that Facility shall be entitled to rely upon the accuracy of the information contained on the card presented.

4.2 **Eligibility Verification.** Plan shall maintain telephone and/or electronic or online services twenty-four (24) hours a day, three hundred sixty five (365) days per year for purposes of allowing Participating Providers to confirm Member eligibility. Plan shall respond to all requests for eligibility determination within four (4) hours following such request. Plan shall notify Facility of other additional means made available to Participating Providers to verify Member eligibility as they become available.

4.3 **Member Loss of Eligibility.** For a Member whose request for Facility services was authorized, and who later becomes ineligible for Plan benefits due to enrollment in another Medicaid Managed Care Plan, Plan must notify Facility within thirty (30) days of inpatient discharge or outpatient date of service that the Member became ineligible. Plan may request a refund of amounts paid for that Member within the above referenced thirty (30) day timeframe, regardless of any alternative time periods provided for under Section 5 of this Agreement. However, if Member returns to coverage under traditional Medicaid fee for service, Plan may request a refund of amounts paid so long as the Medicaid claims filing deadline has not expired, regardless of any alternative time periods provided for under Section 5 of this Agreement. If permitted by Regulatory Requirements, Facility may collect from the Member any amounts for services rendered subsequent to the loss of coverage under the applicable Managed Medicaid Plan unless the Member subsequently qualifies for Medicaid fee for service.

4.4 **Provision of Services.** Facility agrees to provide inpatient and outpatient health care services which Facility makes available to the public to Members in the same manner as provided to other patients and without regard to race, religion, gender, color, national origin, age, source of payment, the type of Managed Medicaid Plan under which the Member has coverage, or physical or mental health status. Plan shall provide services to Members in the same manner as Plan provides those services to Plan's commercial members. The services shall be as accessible to Members as they are for non-Members residing in the same Service Area.

4.4.1 Facility shall provide Covered Services to Members through the last day that this Agreement is in effect and in accordance with the Medicaid MCO Program and the Regulatory Requirements.

4.4.2 Facility shall not refuse to provide Medically Necessary or preventive Covered Services to Members covered under the Medicaid MCO Contract for non-medical reasons.

4.4.3 Plan acknowledges not all Covered Services are available on a 24 hour per day, 7 days per week basis (e.g. cardiac catheterization laboratory, outpatient surgery, certain diagnostic testing, etc.) Accordingly, Plan will not deny Claims or otherwise penalize Facility for services

that are not made available and provided to Members on a 24 hour per day, 7 days per week basis consistent with standards of like facilities in the community.

4.4.4 In cases in which Facility, Plan or a treating physician determines that Emergency Services are required for a Member or instructs that such services be provided to a Member, Facility shall provide such services as are necessary to evaluate, and if necessary, treat to stabilize the condition of the Member without prior approval from Plan, as required by the Regulatory Requirements. Plan shall pay for Emergency Service in accordance with **Attachment A**.

4.4.5 Regardless of any provision to the contrary, Facility, at its sole discretion, may elect at any time during the term of this Agreement to discontinue any type of service at the Facility, provided that such discontinuation shall be as to the general public and not solely as to Plan Members.

4.4.6 Facility agrees to meet State standards for timely access to care and services, taking into account the urgency of the need for services.

4.4.7 Appointment waiting times shall not exceed the following requirements:

- Routine visits scheduled within four (4) to six (6) weeks;
- Urgent, non-emergency visits within forty-eight (48) hours; and
- Emergent or emergency visits immediately upon presentation at a service delivery site;
- Waiting times should not exceed forty-five (45) minutes for scheduled appointment of a routine nature.

Walk-in patients with non-urgent needs should be seen if possible or scheduled for an appointment consistent with written scheduling procedures. Walk-in patient with urgent needs should be seen within forty-eight hours. Facility shall not use discriminatory practices with regard to Members such as separate waiting rooms, separate appointment days, or preference to private pay patients

4.4.8 Facility shall monitor the quality of Covered Services delivered under this 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 Facility operates and/or the standards established by SCDHHS or its designee.

4.4.9 Plan shall permit female enrollees thirteen (13) years of age and older two (2) visits annually without prior referral to the health care services of an obstetrician/gynecologist in the Plan network. Plan's health maintenance organization plans must authorize medically necessary services referred by the obstetrician/gynecologist during these two visits per calendar year without requiring the additional referral of the patient's PCP. S.C. Code Ann. § 38-33-325.3.4.7

4.4.10 All newborns of Members are the responsibility of Plan, unless the Member mother has specified otherwise prior to delivery or SCDHHS does not enroll the newborn into the Plan. To assure continuity of care, Plan shall make every effort to expedite enrollment of newborns into the Member mother's Plan. ~~For Members, SCDHHS will enroll newborns into the same managed care plan as the Member mother for the first ninety (90) calendar days from birth unless otherwise specified by the Member mother. The newborn will be enrolled in the same managed care plan as the Member mother through the end of the month in which the ninetieth (90th) day falls. The newborn's effective date will be the first day of the month of birth. The newborn shall continue to be enrolled with the Member mother's Plan unless the mother/guardian changes the enrollment.~~ Plan shall inform Facility and the newborn's attending and consulting physicians that the newborn is a Plan Member and that Facility should seek reimbursement from Plan. Facility shall notify Plan and SCDHHS of births when the mother is a Medicaid MCO Program Member. Facility shall complete the SCDHHS Request for Medicaid ID Number (Form 1716 ME), ~~including indicating whether the mother is a Medicaid MCO Program Member,~~ ~~and submitting~~and submit the form to the local SCDHHS/State SCDHHS office~~.~~

4.4.11 In accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et. seq.) (2001, as amended) and its implementing regulation at 45 C.F.R. Part 80 (2001, as amended), Facility shall take adequate steps to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and Covered Services provided under this Agreement.

4.4.12 Facility and Plan agree that nothing in this Agreement shall be construed to limit Facility's ability to discuss with a Member the treatment options available to that Member, risks associated with treatments, case management/utilization management decisions, or recommended course of treatment, and nothing in this Agreement shall limit Facility's legal obligations to a Member as specified under the Facility's professional license. However, nothing in this section shall prevent Plan from prohibiting disclosure of trade secrets by Facility. S.C. Code Ann. § 38-71-1740(a)(2).

4.4.13 Facility shall submit all reports and clinical information ~~reasonably~~/ required by the Plan, which submission of reports and clinical information shall not be an undue burden for Facility, including EPSDT (if applicable).

4.5 **Notification of Services.**

4.5.1 Facility will notify Plan of the presentation of a Member to Facility within twenty-four (24) hours or the end of the next business day, whichever is less, of the presentation or the end of the next business day, whichever is greater.

4.5.2 Plan will issue an authorization number within twenty-four (24) hours or the end of the next business day, whichever is less, upon notification that reflects Covered Services from the date of Member's presentation through the date of discharge and physician orders as they relate to patient type (i.e. admission vs. observation) with confirmation by facsimile transmission.

4.5.3 Requests for treatment authorization after notification cannot be held pending for more than twenty-four (24) hours.

4.5.4 Regardless of any provision in this Agreement or Plan policy or procedure to the contrary, in the case of an emergency, Facility is not required to provide notice, obtain coverage verification or prior authorization from Plan prior to providing Emergency Services and Post-Stabilization Services subsequent to a Member inpatient admission.

4.5.5 Where Covered Services were previously authorized by the Plan, payment for those services cannot be retrospectively denied for any reason, other than as described in Section 4.3 for patients who are no longer eligible as Members.

4.6 **Discharge Planning Guidelines**.

4.6.1 Plan will perform continuing inpatient clinical review, actively participate in discharge planning, and will coordinate the physician ordered placement for SNF, DME or home health services with Plan vendors and other Participating Providers, issue the appropriate authorizations to the vendors and communicate same to Facility case management departments via facsimile, electronic or online transmission, or telephone to a pre-designated phone number.

4.6.2 Plan will not deny stays or portions of stays and shall reimburse Facility according to **Attachment A** when Plan reviewers are not available for coordination of discharge plans and cannot find appropriate placement post discharge thus creating discharge delays or when the Member's treating physician creates discharge delays.

4.7 **Plan Policies.** Subject to Facility's policies and bylaws, Facility shall reasonably cooperate with Plan's quality assurance, quality improvement, member grievance and appeal, medical records retention and credentialing criteria policies (the "Plan Policies"), provided that such Plan Policies have been provided to the Facility sixty (60) days in advance of their effective date and Plan has made any reasonable modifications to such Plan Policies that are requested by Facility. Plan Policies shall be consistent with the terms of this Agreement, with Facility's policies and procedures, and with applicable law; commercially reasonable; in writing; and changes thereto will be noticed in writing.

4.7.1 The SCDHHS's policy and procedure manual applicable to the South Carolina Medicaid MCO Program is available in writing or electronically on the SCDHHS website, including (i) the South Carolina Policy and Procedure Guide for Managed Care Organization effective April, 2008, as may be updated from time to time (the "Guide") and (ii) the model contract between SCDHHS and 2008 Managed Care Providers dated as of April 1, 2008 (the "Model Contract"). SCDHHS "policies" are the general principles by which SCDHHS is guided in its management of the Medicaid MCO program, as further defined by SCDHHS promulgations and by state federal rules and regulations. Guide, Definition of Terms, p. 177 (for definition of "Policies").

4.7.2 Further, Facility shall adhere to the ~~reasonable~~ Quality Assessment Performance Improvement ("QAPI") and Utilization Management ("UM") requirements as outlined in the State of South Carolina Medicaid Managed Care Program Policy and Procedure Guide as applicable to Facility. The QAPI and UM Requirements shall be included as part of the

Agreement. Facility shall comply with any reasonable plan of correction initiated by Plan and/or any plan of correction required by SCDHHS. Whether announced or unannounced, Facility shall participate and cooperate in any internal and external reasonable quality assurance review, utilization review, peer review and grievance procedures established by Plan and/or SCDHHS or its designee ~~which~~, so long as the Plan procedures are not unduly burdensome to Facility.

4.7.3 Plan shall provide at least sixty (60) days, or such lesser period of time as may be required by the State Agency, prior written notice to Facility of any modifications to such Plan Policies during the term of this Agreement. Facility agrees to communicate to Plan any inquiries, issues or objections to the above referenced modifications to Plan Policies within the above referenced notice period. Plan shall respond to Facility communications related to such policies in a timely manner. Notwithstanding anything to the contrary, Plan Policies are guidelines, and as such shall not be incorporated as a term of this Agreement.

4.7.4 Plan agrees to provide Facility with instruction as to its authorization procedure(s) for Participating Facilities, to use when verifying eligibility and coverage of Members and/or when seeking pre-authorization for services.

4.7.5 Regardless of any past, present or future provision, policy, procedure, methodology, rule, manual, guideline, UR criteria or other data/document/process, and/or any change therein, to the contrary, Plan may not unilaterally change, reduce, modify or otherwise adjust downward the reimbursement set out in this Agreement.

4.7.6 Plan agrees that by law it may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the Member.

4.7.7 Plan agrees that it must provide written notification to Facility and give the Member written notice of any decision by the Plan to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested, and that such notice must comply with applicable state and federal rules and regulations and Medicaid MCO Program requirements.

4.7.8 Plan agrees that it must, by law, compensate individuals or entities that conduct utilization management activities so that payment is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary services to any Member.

4.7.9 Plan shall maintain an organized, integrated Member services function to assist Members in understanding Plan's policies and procedures. Plan's Member services function should provide additional information about the Plan's Primary Care Providers, facilitate referrals and assist in the resolution of service and/or medical delivery concerns or problems a Member may have. The Plan shall identify and educate Members who access the system inappropriately and provide Members additional education as needed.

4.8 **Member Grievances.** Facility ~~agrees to reasonably~~shall cooperate with Plan in identifying and resolving Member complaints and grievances pursuant to the grievance procedures of Plan, except to the extent Facility would be required to admit legal liability, waive

an existing or potential legal claim, or waive a right under this Agreement. Plan shall provide a written report that identifies the Member or Facility grievance and/or complaint, action taken and outcome. Plan shall make available to Facility a copy of the Plan Member handbook through the Plan website or by providing a physical copy upon request.

4.9 **Facility Based Providers.** Facility may employ or contract with certain Facility-based providers such as emergency room physicians, pathologists, radiologists, anesthesiologists, neonatologists, certified registered nurse anesthetists ("CRNAs") and intensivists.

4.9.1 Subject to any legal or administrative restrictions and in accordance with Facility's policies, procedures and bylaws, Facility agrees to provide Plan with information regarding such Facility-based providers' clinical privileges at Facility.

4.9.2 If Plan is unable to obtain participation agreements with such Facility-based providers rendering services at Facility, Facility agrees to assist Plan with introductory meetings.

4.9.3 The parties agree that reimbursement for professional services rendered to Members by such Facility-based providers is not covered by this Agreement and shall be billed independently by such providers.

4.10 **Regulatory Requirements.** Notwithstanding any other statement in this Agreement or its attachments to the contrary, Plan and Facility acknowledge and agree that this Agreement is subject to applicable Regulatory Requirements in effect as of the Effective Date.

4.11 **Advance Directives.** The parties agree to comply with the Patient Self-Determination Act and other state and federal laws, rules and regulations regarding patient advance directives, as they may be amended from time to time and to the extent applicable.

4.12 **Rate Load.** Plan agrees to load the reimbursement rates herein into its claims processing system prior to the Effective Date of this Agreement. Each party shall designate a representative to address issues associated with processing Claims. Plan agrees to provide reasonable on-site and electronic access to Facility's representatives to verify that reimbursement rates have been accurately loaded. In addition, Plan agrees to provide Facility with printouts of the rates actually loaded into the Plan's claims processing system within thirty (30) days after the Effective Date and within thirty (30) days of any amendments to the rates.

4.13 **Plan Confirmation of Member Expense Obligation.** Upon request of Facility, Plan will provide Facility with a letter on Plan letterhead that states that it is the Facility's right to collect and the Member's responsibility to pay Member Expenses at the time of service.

4.14 **Adequate Network**. Plan shall maintain an adequate network of Participating Providers to provide coverage to Members. Plan shall at a minimum contract with at least one tertiary care center in the Service Area for each of the following: (i) Neonatal services and Perinatal services; (ii) Pediatric services; (iv) Trauma Services; (v) Burn Services and (vi) adequate facilities for post discharge services.

4.15 **Conflict of Interest**. Facility represents and covenants that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or

degree with the performance of its services hereunder. The Facility further covenants that, in the performance of the Agreement, no person having any such known interests shall be employed.

4.16 **Provider Bill of Rights**. Plan shall abide by the following Provider Bill of Rights adopted by SCDHHS:

4.16.1 Plan shall provide information on the Grievance, Appeal and Fair Hearing procedures.

4.16.2 Plan shall provide access to its policies and procedures covering the authorization of services.

4.16.3 Plan shall notify Facility of any decision by Plan to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.

4.16.4 Plan shall permit Facility to challenge, on behalf of the Medicaid Plan Members, the denial of coverage of, or payment for, medical assistance.

4.16.5 Plan's provider selection policies and procedures will not discriminate against Facility on the basis that it serves high-risk populations or specializes in conditions that require costly treatment.

4.16.6 Plan shall not discriminate against Facility with respect to the participation, reimbursement, or indemnification of Facility so long as Facility is acting within the scope of its license or certification under applicable State law, solely on the basis of that license or certification.

4.16.7 A health care professional, acting within the lawful scope of practice, shall not be prohibited from advising or advocating on behalf of a Member who is his/her patient, for the following:

- The health status of the Member or medical care or treatment options for the Member's condition or disease, including any alternative treatment that may be self-administered, regardless of whether benefits for such care or treatment are provided under this Agreement;
- Any information the Member needs in order to decide among all relevant treatment options;
- The risks, benefits, and consequences of treatment or non-treatment; and
- The Member's right to participate in decisions regarding his/her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

SECTION 5

REIMBURSEMENT PROVISIONS

5.1 **Payment.** Plan shall reimburse Facility for Covered Services rendered to Members at the rates set forth on **Attachment A**, less Member Expenses that will be collected from the Member. The obligation for payment under this Agreement for Covered Services rendered to a Member is solely that of Plan, except that Facility may also seek payment from a Member for Member Expenses or Non-Covered Expenses, to the extent permitted by Regulatory Requirements and if such Member Expenses are permitted by the Managed Medicaid Plan. Facility shall provide the name and address of the official payee to whom payment may be made and promptly submit all information needed for Plan to make payment to Facility.

5.1.1 If Plan provides for electronic remittances (ERA) and/or the electronic payment of Claims (EFT) to any other Facility provider, upon execution of this agreement Plan will promptly take steps to assure Facility can electronically receive remittances (ERA) and/or the electronic payment of claims (EFT) in accordance with policies and procedures established by Facility and Plan, and in accordance with the pricing of new codes and new services and procedures, as described in Section 5.2 below.

5.1.2 If Plan cannot administer and accurately pay the contracted rates, negotiations can be opened at any time to resolve rate structure adjudication issues.

5.1.3 Plan is liable and must pay Facility for any Covered Services provided to Members which are authorized by the Plan or its agent unless Facility knowingly provided false and misleading information upon which the authorization was granted.

5.1.4 Plan shall not retroactively deny a Claim for Emergency Services because the condition, which appeared to be an Emergency Medical Condition under the prudent layperson standard, was determined to be a non-emergency. The Plan shall not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms. The Plan shall not refuse to cover Emergency Services based on the emergency room provider, hospital, or fiscal agent not notifying the Member's PCP, Plan or applicable State entity of the Member's screening and treatment within ten (10) calendar days of presentation for Emergency Services. The Plan shall not deny payment for treatment when a representative of the entity instructs the Member to seek Emergency Services. The Plan shall not deny payment for treatment obtained when a Member had an Emergency Medical Condition and the absence of immediate medical attention would not have had the outcomes specified in 42 CFR 438.114(a) of the definition of emergency medical condition. The Plan shall be responsible for payment to providers in and out of the Service Area, without requiring prior approval, for Emergency Services and Post-Stabilization Services, including but not limited to the following services and in accordance with the SSA Section 1867 (42 U.S.C. 1395dd): 1) Determining if an emergency exists for Medicaid MCO Program Members when the medical screening service is performed; 2) Treatment as may be required to stabilize the medical condition, including emergency admissions; and 3) Transfer of the individual to another medical facility within SSA Section 1867 (42 U.S.C. 1395 dd) guidelines and other applicable State and federal regulations. Plan shall prior approve any services performed after the Facility, whether in or out of the Service Area, has stabilized the patient. Plan shall cover services subsequent to stabilization if: 1) said services were pre-approved by the Plan; 2) said services were not pre-approved by the Plan because the Plan did not respond to the Facility's request for pre-approval of said services within one (1) hour after the request was made; 3) Plan could not be contacted for pre-approval; or 4) Plan and the treating

physician cannot reach an agreement concerning the Member's care, and a network physician is not available for consultation. In this situation, the Plan shall give the treating physician the opportunity to consult with a network physician and the treatment physician may continue with the care of the Member until a network physician is reached or one of the criteria of 42 CFR 422.133(c)(3) is met.

5.1.5 The Plan's financial responsibility for Post-Stabilization Services it has not pre-approved ends when 1) a network physician with privileges at the treating hospital assumes responsibility for the Member's care; 2) a network physician assumes responsibility for the Member's care through transfer; 3) a representative of the Plan and the treating physician reach an agreement concerning the Member's care; or 4) the Member is discharged.

5.1.6 Plan agrees that it will not deny payment solely because Facility fails to verify eligibility or pre-authorization for services rendered to Members. This will not relieve Facility of its obligations in the normal course of business to make responsible attempts to obtain authorization for non-emergency services.

5.1.7 If Facility's Claim is partially or totally denied in a remittance advice or other appropriate written notice, then Facility may submit an appeal for reconsideration to Plan within twelve (12) months of the receipt of the partial or total denial of the Claim. The reconsideration request should include any documentation or information reasonably necessary to support the appeal for reconsideration. Plan must respond to the reconsideration request within sixty (60) days after receipt of the request.

5.1.8 Notwithstanding any provision in this Agreement to the contrary, Facility may appeal and Plan shall review Claims that were totally or partially denied for Facility's failure to i) file a Claim within the time limit set forth in this Agreement; ii) provide a notice required by this Agreement; iii) follow Plan Policies; iv) determine eligibility; or v) obtain an authorization required by this Agreement, to determine if the services rendered were Covered Services, were Medically Necessary and would have been authorized. If in its evaluation of Facility's reconsideration request, Plan reasonably determines that the services provided by Facility, including but not limited to outpatient diagnostic imaging services, were Covered Services, were Medically Necessary and appropriate for the Covered Person's condition, and would have been authorized by Plan, then Plan shall reverse its denial and reimburse Facility in accordance with **Attachment A** within twenty (20) days of such determination. If, in its evaluation of Facility's appeal, Plan reasonably determines that the services in question were Non-Covered Services, and/or were not Medically Necessary and appropriate for the Covered Person's condition, and would not have been authorized by Plan even had Facility not failed to comply with the administrative programs, policies, procedures, or Plan Policies, then Plan may uphold its denial, subject to Facility's right to pursue whatever additional remedies may be available to it.

5.1.9 Notwithstanding any provision herein to the contrary, Facility shall be reimbursed for any services provided pursuant to Member's successful appeal, grievance or request for continuation of services.

5.2 **Submission of Claims.** Facility shall submit initial Claims with applicable coding including, but not limited to, DRG, ICD9-CM, CPT, Revenue and HCPCS coding in accordance

with the following time periods: (a) when Plan is primary, within one hundred eighty (180) days following the date of discharge for inpatient services or the date of service for all other services; (b) when Plan is secondary, within one hundred eighty (180) days following the final determination of the primary insurer; or (c) when Facility is not aware that the patient is a Member, within one hundred eighty (180) days following the date Facility is provided with information identifying the patient as a Member. Facility shall not, under any circumstances, submit a Claim for payment more than three hundred sixty-five (365) days from the date of service. Plan will accept as accurate the final DRG billed by Facility if that DRG was accurately determined using the then current ICD-9-CM/DRG grouper as published by the Federal Register through Facility Health Information Management department.

5.2.1 If Plan provides for the electronic submission of claims by any other Participating Provider, upon execution of this agreement, Plan will promptly take steps to assure Facility can electronically submit Claims in accordance with policies and procedures established by Facility, Plan and their respective claims clearinghouses.

5.2.2 Plan agrees not to perform any acts of bundling or unbundling of services on claims submitted and their related coding that is inconsistent with Medicaid protocols, as such protocols may be amended from time to time pursuant to Section 5.11. Plan will follow the billing guidelines established by CMS for Inpatient and Outpatient and consistent with South Carolina Medicaid Payment Systems that define a covered charge.

5.2.3 Plan will allow for the interim billing of Claims and payment thereof every thirty (30) day period of continuous care, when Members receive services from Facility over more than a thirty (30) day period.

5.3 **Prompt Pay.** Plan shall pay any and all uncontested portions of Claims submitted within thirty five (35) days of Receipt or such shorter time frame as required by applicable Regulatory Requirements. Plan shall pay ninety percent (90%) of all Clean Claims from Facility, either in individual or group practice or who practice in shared health facilities, within thirty (30) days of the date of Receipt. Plan shall pay ninety-nine percent (99%) of all Clean Claims from Facility, either in individual or group practice or who practice in shared health facilities, within ninety (90) days of the date of Receipt. Plan and Facility may, by mutual agreement, establish an alternative payment schedule.

5.3.1 Plan agrees not to delay payment for coordination of benefits or third party liability unless coordination of benefits or third party liability has been determined to actually exist. Plan further agrees to accept and utilize in its coordination of benefits or third party liability determination any information (if applicable) obtained from Member on forms created by Facility and made available to Plan upon request.

5.3.2 If Plan contests Facility's Claim or any portion of a Claim, Plan shall notify Facility in writing within thirty (30) days after Receipt of the Claim by Plan that the Claim is contested. The notice that the Claim is contested must specifically identify the contested portion of the Claim and the specific reason for contesting the Claim, and must include a request identifying the specific additional information required. If Plan requests additional information, Facility must, within thirty-five days (35) after receipt of such request, mail or electronically

transfer the information to Plan. Plan shall pay the claim or portion of the claim within forty-five (45) days after receipt of the requested information.

5.3.3 Notwithstanding anything to the contrary or additional information requested and in all cases, Plan shall pay or deny any Claim submitted no later than one hundred twenty (120) days after receiving the Claim. Failure to do so shall create an uncontestable obligation to pay the Claim.

5.3.4 Payment of a Claim is considered made on the date the payment was received by or electronically transferred to Facility.

5.3.5 If Plan has entered into a capitated reimbursement arrangement with Facility, all encounter data submissions shall be subject to the same standards of completeness and accuracy as required for proper adjudication of fee-for-service claims.

5.3.6 The parties agree that all Medicaid benefit determinations are within the sole and exclusive authority of SCDHHS.

5.4 **Reimbursement for FQHC/RHC Covered Services.** If Facility is a FQHC/RHC, the following shall apply:

5.4.1 Plan shall adhere to federal requirements for reimbursement for FQHC/RHC Covered Services. This Agreement shall specify the agreed upon payment from Plan to the FQHC/RHC. Any bonus or incentive arrangements made to the FQHC/RHC associated with Members must also be specified to SCDHHS. The Plan shall submit the name of the FQHC/RHC and number of Medicaid encounters paid to each FQHC/RHC by month of services to the SCDHHS for State Plan required reconciliation purposes. This information shall be submitted in the format required by SCDHHS as contained in the MCO Policy and Procedure Guide.

5.4.2 Plan shall not make payment to a FQHC/RHC which is less than the level and amount of payment which Plan makes for similar Covered Services if the Covered Services were furnished by a provider which is not a FQHC/RHC.

5.4.3 Plan shall not make payment to a FQHC/RHC which is less than the level and amount of payment the FQHC/RHC would have been entitled to receive as reimbursement from the South Carolina Medicaid Program for a fee-for-service claim.

5.5 **Overpayment/Underpayment Process.** All Plan requests for refund of overpayments shall be submitted in writing. Facility detailed Claim level requests for amounts underpaid shall be submitted electronically or in writing. Plan will be obligated to respond to underpayment requests provided with Claim level detail that includes the specific reasons for non-payment in a format acceptable to Facility. The other party shall thereafter respond within thirty-five (35) days following receipt of such request.

5.5.1 Regardless of any provision to the contrary, no request shall be allowed for any alleged overpayment or underpayment made more than three hundred and sixty-five (365) days from inpatient discharge dates and outpatient service dates, as applicable. Neither party has a

right of offset, any right of retroactive reductions in payment, or any right to demand a refund of alleged overpayment or underpayment unless performed in accordance with this Section 5.5.1 and mutually agreed upon in writing by the parties.

5.5.2 Both Plan and Facility agree that neither will seek overpayment or underpayment recovery from the other for any individual Claim where the aggregate (not per unit) discrepancy is less than fifty dollars ($50) for inpatient or outpatient services. This waiver of overpayment or underpayment recovery does not apply to systemic issues that may be found by either party relative to contracted rates, which will be corrected in accordance with this Agreement. If after formal correspondence between the parties, resolution of systemic payment issues is not achieved; either party can give thirty (30) days notice to delete the waiver from this Agreement.

5.5.3 In the event that the State Agency notifies the Plan that it will seek overpayments from Facility, Plan shall notify the Facility within five (5) business days of receipt of such notice by the State Agency.

5.6 **Coordination of Benefits.** Subject to applicable state and federal laws and regulations regarding confidentiality of medical and personal information, Plan and Facility agree to reasonably cooperate to exchange information relating to coordination of benefits and third party liability with regard to Covered Services rendered to a Member, including without limitation, claims that may be covered by automobile insurance, workers' compensation coverage, other health insurance, or otherwise give rise to a claim for third party liability. The parties agree to inform each other in writing of the receipt of any payment for Covered Services received from sources other than Plan. The execution of this Agreement in no way waives Facilities right to bill and collect from Plan as a secondary or tertiary insurer to Member's primary insurer, including the billing and collection from Plan of Member co-payments, coinsurance, deductibles and/or other cost-share amounts.

5.7 **Member Protection Provision.** To the extent specifically prohibited by law and the Medicaid MCO Program:

5.7.1 Facility agrees that in no event, including, but not limited to, non-payment by Plan, insolvency of Plan, or breach by Plan of this Agreement, shall Facility bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Member for Covered Services provided pursuant to this Agreement, other than Member Expenses. Facility shall accept payment made by Plan as payment-in-full for Covered Services provided and shall not solicit or accept any surety or guarantee of payment from the Member, or the parents, guardian, spouse or other legally responsible person of the Member. Facility or its designated agent shall execute the Hold Harmless Agreement attached hereto as **Attachment D**.

5.7.2 The provisions of this Section 5.7 shall be construed in favor of the Member, shall survive the termination of this Agreement regardless of the reason for termination, including the insolvency of Plan, and shall supersede any oral or written contrary agreement between Facility and a Member or the representative of a Member.

5.7.3 The Plan shall not refuse to compensate the Facility for Covered Services or otherwise disadvantage the Facility because the Facility, its employees, medical staff, vendors, or anyone else contracted with or in anyway affiliated with the Facility, have in good faith communicated with or advocated on behalf of one or more of its prospective, current or former Members regarding the provisions, terms or requirements of the Plan's Managed Medicaid Plans as they relate to the needs of the Member; or communicated with one or more of its prospective, current or former Members with respect to the method by which the Facility is compensated by the Plan for Covered Services provided to the Member.

5.8 **Member Expenses.**

5.8.1 Plan agrees that Facility may pursue collection of Member Expenses at any time prior to, during or after services are rendered, if permitted by the Managed Medicaid Plan.

5.8.2 Subject to any Regulatory Requirements and Facility's policies, procedures and bylaws, Facility may waive all or any portion of Member Expenses that may be required under a Member's Managed Medicaid ~~Plans~~Plan without the prior written consent of Plan. Plan agrees to cooperate with all Facility policies and procedures for the collection of Member bad debt.

5.8.3 Subject to any Regulatory Requirements, Facility may pursue collection of Non-Covered Services.

5.9 **Claims Disputes.** The parties agree to attempt to resolve disputes involving Claims payment, denial, overpayment or underpayment issues directly. Should the parties fail to resolve such issues directly, ongoing disputes shall be resolved in accordance with Section 9, Dispute Resolution, below.

5.9.1 In the event Facility does not file a Claim for medical services rendered to a Member within the timeframes outlined above, or fails to follow Plan's practices, including prior authorization due to Member's failure to provide Facility with an accurate identification card in a timely manner, Plan will adjudicate and pay the Facility's Claim based on whether the services in question (a) were Covered Services; (b) were Medically Necessary and appropriate for the Member's condition; and (c) would have been authorized or paid by Plan had Facility received accurate and timely identification card information from the Member at the time of service or had complied with Plan practices.

5.10 **New Technology and Services**. To the extent that Facility expands or adds a new type of service or technology, or provides Covered Services to a Member that were not offered by Facility or not priced in **Attachment A** on the Effective Date of the initial or any renewal term, the parties will negotiate rates for such services for up to a sixty (60) day period following notice to Plan by Facility. Upon agreement on a reimbursement rate for such new service or technology, the parties shall amend **Attachment A** to include such service and the corresponding rate. Plan agrees to promptly load the reimbursement rate pursuant to Section 5.1. If the parties cannot reach an agreement on the application of existing rates or as to new rates for the services affected by the end of this sixty (60) day period, Facility will be considered a non-participating provider for that service until such time as the parties may mutually agree upon other rates for such services.

5.11 **New and Updated Coding**. In the event Medicare or the AMA reclassify, add, change or delete Diagnosis-Related Groups ("DRGs") and descriptions and/or Current Procedural Terminology ("CPT") codes and descriptions that affect a service definition for inpatient or outpatient services, and as such alterations may relate to Covered Services specified in the rate sheets incorporated into **Attachment A**, the parties will meet in good faith to negotiate rates for a thirty (30) day period following notice by one party to the other of such coding modification(s). The intent of both parties during the negotiation period will be to align the coding modifications with payment rates existing in the then current rate sheets or with new rates that reflect the service being delivered, such that the financial impact is neither to the detriment of nor benefit to either party. From the period beginning with the effective date of the modification by Medicare or AMA to the service definitions (effective as of October 1 for DRG code changes, as of January 1 for CPT codes changes, and as of the effective date of any other modifications by CMS to the outpatient coding), to the end of the thirty (30) day period, payment for the modified service definition shall fall to and be mapped to the most applicable rate on the then current rate sheets, notwithstanding that components may have been added or subtracted from such service definition. Plan acknowledges that Facility's Claim will reflect the new inpatient or outpatient payment methodology codes, and Plan will use an internal mapping process to make payment using the payment methodology in place prior to the effective date of the applicable coding modifications until Plan completes its implementation of modifications in coding. In the event the parties cannot reach an agreement on the application of existing rates or new rates for the services affected by the expiration of the thirty (30) day period, Facility shall be paid at **thirty** percent (30%) of Billed Charges for such Covered Services until such time as the parties may mutually agree upon rates for such services. For purposes of determining payment under this Agreement, the parties acknowledge and agree that the modifications in coding and the respective revised payment methodology referenced herein shall be calculated retroactive to the respective effective date of such modification in coding, and that payment for such affected Claims shall be reconciled accordingly.

5.12 **Disclosure of Payment by Plan to SCDHHS**. Facility shall fully disclose to regulatory authorities the method and amount of compensation or other consideration to be received from Plan upon request.

SECTION 6

LIABILITY OF PARTIES, LAWS, REGULATIONS AND LICENSES

6.1 **Legal Responsibility.** Facility and Plan agree that each is responsible for the legal consequences and costs of its own acts or omissions, or both, and is not responsible for the acts or omissions, or both, of the other party. However, nothing in this section shall be construed to subject Plan liability for clinical decisions made solely by Facility, and nothing in this section limits that ability of Plan to otherwise prudently administer its provider contracts.

6.2 At all times during the term of the Agreement, Facility shall indemnify and hold SCDHHS harmless from all claims, losses, or suits relating to activities undertaken pursuant to the Medicaid MCO Contract unless the Facility is a state agency. For all Facilities that are not state agencies, Plan shall indemnify, defend, protect, and hold harmless SCDHHS and any of its officers, agents, and employees from:

6.2.1 Any claims for damages or losses arising from services rendered by any subcontractor, person, or firm performing or supplying services, materials, or supplies for the Plan in connection with the performance of this Agreement;

6.2.2 Any claims for damages or losses to any person or firm injured or damaged by erroneous or negligent acts, including disregard of State or federal Medicaid regulations or legal statutes, by Plan, its officers, employees, or subcontractors in the performance of this Agreement;

6.2.3 Any claims for damages or losses resulting to any person or firm injured or damaged by Plan, its officers, employees, or subcontractors by the publication, translation, reproduction, delivery, performance, use, or disposition of any data processed under this Agreement in a manner not authorized by the Agreement or by federal or State regulations or statutes;

6.2.4 Any failure of the Plan, its officers, employees, or subcontractors to observe the federal or State laws, including, but not limited to, labor laws and minimum wage laws;

6.2.5 Any claims for damages, losses, or costs associated with legal expenses, including, but not limited to, those incurred by or on behalf of SCDHHS in connection with the defense of claims for such injuries, losses, claims, or damages specified above;

6.2.6 Any injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against SCDHHS or their agents, officers or employees, through the intentional conduct, negligence or omission of the Plan, its agents, officers, employees or subcontractors.

6.3 In the event that, due to circumstances not reasonably within the control of Plan or SCDHHS, (i.e., a major disaster, epidemic, complete or substantial destruction of facilities, war, riot or civil insurrection), neither the Plan, SCDHHS, subcontractor(s), or Facility will have any liability or obligation on account of reasonable delay in the provision or the arrangement of Covered Services; provided, however, that so long as the Plan's certificate of authority remains in full force and effect, the Plan shall be liable for the Covered Services required to be provided or arranged for in accordance with the terms of this Agreement.

6.4 **Facility Insurance.** Facility will maintain all such policies of liability and malpractice insurance, or self insurance for said coverage, as shall be necessary to adequately protect Plan's Members and to insure Facility against any claims for damages arising in connection with the performance of Facility's responsibilities under this Agreement. Facility shall provide such insurance coverage at all times during the term of the Agreement and, upon execution of the Agreement, shall furnish Plan with written verification of the existence of such coverage. This clause shall survive for a period of time following the termination of this Agreement not less than the applicable statute of limitations. Facility agrees to provide, and/or have its insurance carrier(s) provide written notice to Plan at least ten (10) days prior to any suspensions, cancellations and/or adverse modifications to the above noted professional liability insurance coverage.

6.5 **Plan Insurance.** Plan will maintain such policies of professional liability, general liability insurance, workers' compensation as required by law, and other insurance, or self insurance for said coverage, as shall be necessary to insure Plan against any claims for damages arising in connection with the performance of Plan's responsibilities under this Agreement. Upon request, Plan shall provide Facility with a current certificate of insurance as reasonable proof that Plan has obtained adequate insurance coverage. This clause shall survive for a period of time following the termination of this Agreement not less than the applicable statute of limitations. Plan agrees to provide, and/or have its insurance carrier(s) provide written notice to Facility at least ten (10) days prior to any suspensions, cancellations and/or modifications to the above noted insurance coverage.

6.6 **Laws, Regulations and Licenses.**

6.6.1 Facility shall be currently licensed and/or certified under applicable State and federal statutes and regulations and shall maintain throughout the term of this Agreement all necessary licenses, certificates, registrations and permits as are required to provide the health care services and other related activities delegated by Plan hereunder. During the term of this Agreement, Facility agrees to maintain Joint Commission on Accreditation of Healthcare Organization (JCAHO) accreditation for acute care hospitals. Facility will give immediate, written notification by certified mail of any administrative legal action or complaint filed and prompt notice of any claim made against Facility by a subcontractor or Member which may result in litigation related to the Medicaid MCO Contract. Further, Facility shall promptly notify Plan in writing of restriction, revocation or suspension to its license, certification or JCAHO accreditation, whether voluntary or involuntary, that materially restricts Facility's ability to meet its obligations under this Agreement. Facility shall recognize and abide by all Regulatory Requirements.

6.6.2 If Facility performs laboratory services, Facility shall meet all applicable State and federal requirements related to the provision of laboratory services, including but not limited to having a Clinical Laboratory Improvement Amendment (CLIA) Certificate of Waiver or Certificate of Registration with a CLIA identification number. Facility can only provide services that are consistent with its type of CLIA certification.

6.6.3 Plan shall maintain all licenses, certifications, permits, and financial solvency and reserve requirements, without material restriction, which are required to enter into a Medicaid MCO Contract and a Participating Facility agreement according to applicable state and federal law, including without limitation accreditation by an authorized accreditation organization or entity. During the term of this Agreement, Plan agrees to maintain National Committee for Quality Assurance (NCQA) accreditation for health plans. Plan will promptly notify Facility in writing of restriction, revocation or suspension to its license, certification or NCQA accreditation, whether voluntary or involuntary. Plan shall comply with all applicable state and federal rules and regulations.

6.6.4 Plan represents that it has and will maintain the minimum statutory reserve, deposit, surplus and other insolvency protections as required the Regulatory Requirements and will provide Facility with a copy of all financial filings required pursuant to the Regulatory Requirements. Should Plan fail to comply with the foregoing representation at any time, Plan

shall notify Facility of its failure to meet minimum statutory reserve requirements and provide a description of the plan to cure the statutory reserve deficiency.

SECTION 7

NOTICES AND DELIVERY OF NOTICES

7.1 **Delivery of Notices.** Unless otherwise specified in this Agreement, any notice or other communication required or permitted shall be in writing. All written notices or communication shall be deemed to have been given when delivered in person, or upon receipt when delivered by first-class United States mail, proper postage prepaid with signature required, or the next business day following the date notice is provided via overnight delivery. All notices shall be properly addressed to the appropriate party at the address set forth below or to another more recent address of which the sending party has received written notice. Notwithstanding the previous sentence, all notices of termination of this Agreement by either party must be sent by certified mail, return receipt requested. Each party shall provide the other with any changes to their respective addresses for notice below.

Plan:	Select Health of South Carolina, Inc. P.O. Box 40849 Charleston, SC 29423 Attn: Rob Aubrey, Chief Financial Officer
Facility:	South Atlantic Division 900 Island Park Dr, Suite 202A Daniel Island, SC 29492 Attn: Chief Financial Officer
With a Copy to:	East Florida Division 450 East Las Olas Blvd, Suite 1100 Ft. Lauderdale, FL 33301 Attn: Regional Vice President, Managed Government Programs Orange Park Shared Service Center 335 Crossing Blvd Orange Park, FL 32073 Attn: Vice President, Managed Care HCA Inc. Legal Department 1 Park Plaza, Bldg 1-4E Nashville, TN 37203 Attn: General Counsel

SECTION 8

RECORDS

8.1 **Confidentiality of Member Information and Records.** Plan and Facility shall ~~use commercially reasonable efforts to~~ preserve the confidentiality of Member information and records in accordance with applicable state and federal laws, statutes and regulations, including without limitation HIPAA.

8.1.1 To the extent required by applicable Regulatory Requirements, the parties shall ~~use commercially reasonable efforts to~~ obtain any Member consent required in order to provide the other with requested information and records or copies of records for the purpose of paying Claims. As part of its admission process, Facility routinely includes written requests for the patient's consent to provide documents and information to the patient's insurer for this purpose.

8.1.2 Facility shall safeguard Member information according to applicable Regulatory Requirements and Plan's written safeguards, which shall require that Facility (i) meet the requirements of 42 CFR Part 431, Subpart F (2005, as amended) and S.C. Code R. 126-170 et seq. (Supp. 2000, as amended); (ii) comply with any stricter State or federal confidentiality standards which apply to specific types of information or information obtained from outside sources; (iii) require the written consent of the Member or potential Member before disclosure of information about him or her; (iv) not prohibit the release of statistical or aggregate data which cannot be traced back to particular individuals; and (v) acknowledge that violators will be sanctioned.

8.1.3 Facility further acknowledges that all material and information, in particular information relating to Members or potential Members, which is provided to or obtained by or through the Plan's performance under the Medicaid MCO Contract, whether verbal, written, electronic file, or otherwise, shall be reported as confidential information to the extent confidential treatment is provided under State and federal laws.

8.1.4 All information as to personal facts and circumstances concerning Members or potential Members obtained by the Facility shall be treated as privileged communications, held confidential, and not divulged without the written consent of Plan or SCDHHS or the Member/potential Member, provided that nothing stated herein shall prohibit the disclosure of information in summary, statistical, or other form which does not identify particular individuals. The use or disclosure of information concerning Members/potential Members shall be limited to purposes directly connected with the administration of the Medicaid MCO Contract.

8.2 **Maintenance of Records.** As applicable, the parties respectively will maintain medical, eligibility, enrollment/disenrollment, financial and other administrative records related to Members and Covered Services rendered by Facility to Members under this Agreement in such form and such time periods as required by applicable State and federal laws, licensing, accreditation and reimbursement rules and regulations to which the parties are subject and in accordance with industry standards. Specifically, Facility shall maintain an adequate record system for recording services, service providers, charges, dates and all other commonly accepted 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). The medical records shall be legible, maintained in detail consistent with good medical practice and includes medical charts, prescription orders, diagnoses for which medications were administered or prescribed, orders for

laboratory, radiological EKG and other tests and the results of the tests and other documentation sufficient to disclose the quality, quantity, appropriateness and timeliness of the Covered Services. Members and their representatives shall be given access to any requested copies of the Members' medical records, to the extent and in the manner provided by S.C. Code Ann. §44-115-10 et. seq., (Supp. 2000), as amended and subject to reasonable charges.

8.3 **Retention of Records.**

8.3.1 Unless the longer period required pursuant to Section 8.3.2 applies, any and all member records, whether financial, medical or otherwise, shall be retained for a period of three (3) years after the last payment was made for services provided to a Member and retained further if the records are under review or audit until the review or audit is complete. This requirement pertains to the retention of records for Medicaid purposes only; other State or federal rules may require longer retention periods. For example, pursuant to S.C. Code Ann. § 44-115-120, physician Providers shall retain all Member medical records at the site where the medical services are provided, for at least ten (10) years for adult patients and at least thirteen (13) years for minors. These minimum record keeping periods begin to run from the last date of treatment.

8.3.2 Facility shall retain and safeguard all records originated or prepared in connection with Facility's performance of its obligations under the Medicaid MCO Contract, including but not limited to, working papers related to the preparation of fiscal reports, medical records, progress notes, charges, journals, ledgers, and electronic media, in accordance with the terms and conditions of the Medicaid MCO Contract. Facility further 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 Medicaid MCO Contract, and as further required by SCDHHS for a period of five (5) years from the expiration date of the Medicaid MCO Contract, including any Contract extensions. If any litigation, claim or other actions involving the records have been initiated prior to the expiration of the five (5) 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 five (5) year period, whichever is later. If Facility stores records on microfilm or microfiche, Facility must produce, at its expense, legible hard copy records upon request of State or federal authorities, within fifteen (15) calendar days of the request.

8.4 **Government Agency Access.** ~~Subject to~~In accordance with Facility's policies, procedures and bylaws, Facility shall permit SCDHHS, U.S. Department of Health and Human Services (HHS), CMS, Office of Inspector General Comptroller, State Auditor's Office, and the South Carolina Attorney General's Office to evaluate through audit, inspection, or other means, whether announced or unannounced, any records pertinent to this Agreement, including the quality, appropriateness and timeliness of Covered Services and the timeliness and accuracy of encounter data and practitioner claims submitted to Plan. Plan shall cooperate with any such evaluation, and when performed. Upon request of the above federal and State entities, Plan shall assist in such reviews.

8.5 **Audits.** Plan and Facility shall have the right to conduct audits of the other, no more than one (1) time per calendar year, provided that such audits shall be conducted pursuant to procedures in this Agreement. Regardless of anything to the contrary, Plan audit requests shall be submitted in writing, which requests shall include the proposed commencement date and the

type and scope of the audit. Following receipt of any such Plan audit requests, Facility will communicate with Plan to discuss alternative date(s), the scope of any such audit request, as well as any issues or concerns regarding the requested audit. The parties must mutually agree on the date, type and scope of any audits conducted prior to commencement of any audit. Plan, and any authorized designee, shall abide by the customary audit policies and procedures established by the Facility and/or its associated patient account services vendor pertaining to the audit of Claims.

8.6 **Copy Costs.** Plan shall pay Facility $1.00 per page or such amount(s) provided for under applicable law, whichever is lesser, for copies of any and all records requested under this Agreement, excluding copies of medical records requested in conjunction with initial claims processing for determination of payment or denial of such claims.

8.7 **Termination of Medicaid MCO Contract.** The parties recognize that in the event of termination of the Medicaid MCO Contract for any of the reasons described in the Medicaid MCO Contract, Plan shall immediately make available to SCDHHS, or its designated representative, in a usable form, any and all records, whether medical or financial, related to the parties' activities undertaken pursuant to this Agreement. The provision of such records shall be at no expense to SCDHHS.

SECTION 9

DISPUTE RESOLUTION

9.1 **Disputes.** Plan and Facility agree that the parties are responsible for resolving any disputes arising with respect to the performance or interpretation of the Agreement, including without limitation disputes regarding Claims payment or denial, in accordance with the provisions of this Agreement. No dispute shall disrupt or interfere with the provisions of services to Members, and the parties shall attempt to resolve promptly any dispute by negotiation between designated representatives of the parties who have authority to settle the dispute. If the matter has not been resolved within sixty (60) days following the date of a party's written request for this negotiation, either party may initiate binding arbitration by providing written notice to the other party.

9.2 **Binding Arbitration.** In the event of a dispute between Plan and Facility which is not resolved as set forth above or which the parties cannot settle by mutual agreement, including without limitation, a dispute involving the interpretation of any provision of this Agreement, the parties' respective obligations under this Agreement, or otherwise arising out of the parties' business relationship (excluding any disputes that are currently the subject of individual or class litigation), such dispute shall be resolved by binding arbitration.

9.2.1 Arbitrations will be conducted by a single arbitrator selected by the parties from a panel of arbitrators created by the American Arbitration Association (AAA). In the event the parties cannot agree on the arbitrator, then the arbitrator shall be appointed by the AAA.

9.2.2 The arbitrator may construe or interpret but shall not vary or ignore the terms of this Agreement, shall have no authority to award extra contractual damages of any kind, including punitive or exemplary damages, and shall be bound by controlling law.

9.2.3 Unless otherwise agreed, any arbitration proceeding under this Agreement shall be conducted in the State in which the affected Facility is located, or, in the event more than one facility is involved, in any county in which a Facility is located in accordance with and subject to the Commercial Arbitration Rules of the American Arbitration Association then in effect, or under such other mutually agreed upon guidelines. Judgment upon the award rendered in any such arbitration may be entered in any court of competent jurisdiction sitting in county and state in which the affected facility is located or application may be made to such court for judicial acceptance and enforcement of the award, as applicable law may require or allow.

9.2.4 Disputes between the parties that involve claims processing and/or payment discrepancies, and/or common issues of fact or law, and/or that affect one or more Facilities, may be brought together in a single arbitration proceeding. Facility, either alone or in conjunction with its Affiliates, may join claims or issues to a pending informal dispute and/or arbitration without exhausting Plan's internal administrative procedures for addressing such claims/issues, if the claims/issues primarily involve related Claims processing and/or payment discrepancies and/or common issues of fact or law as other claims/issues that are part of the existing informal dispute resolution or arbitration.

9.2.5 The submission of any dispute to arbitration shall not adversely affect any party's right to seek preliminary injunctive relief with respect to an actual or threatened termination, repudiation or rescission of the Agreement.

9.2.6 The cost of any arbitration proceeding(s) hereunder shall be borne equally by the parties. Each party shall be responsible for its own attorneys' fees and such other costs and expenses incurred related to the proceedings.

SECTION 10

TERM AND TERMINATION

10.1 **Term.** The initial term of this Agreement shall be for one (1) year beginning October 1, 2009 and expiring September 30, 2010. Unless either party notifies the other no less than ninety (90) days prior to the expiration of the current term of the Agreement that it does not intend to renew the term of the Agreement, this Agreement shall automatically renew for subsequent one (1) year terms.

10.2 **Termination.** This Agreement may be terminated as follows:

(a) By mutual agreement of Plan and Facility;

(b) By either party, in the event of a material breach of this Agreement by the other party, upon thirty (30) days prior written notice to the other party. The breaching party has the right to cure the breach within thirty (30) days;

SECTION 11

MISCELLANEOUS

11.1 **Amendment.** This Agreement and its attachments may be amended or modified only by the mutual written agreement of the parties. The parties agree to incorporate by reference into the Agreement all Regulatory Requirements, and any revisions of such Regulatory Requirements as they become effective. In the event that changes in the Agreement as a result of revisions and applicable federal or State law materially affect the position of either party, the parties agree to negotiate such further amendments as may be necessary to correct any inequities.

11.2 **Assignment/Change of Control.**

11.2.1 The parties agree to provide the other with written notice of any change in the party's name, ownership, Medicare or Medicaid certification number, or Federal Tax I.D. number, as applicable.

11.2.2 The parties acknowledge and agree that no provision contained herein restricts Facility from contracting with another MCO or other managed care entity. However, with respect to Covered Services provided under this Agreement, Facility shall not enter into any subcontracts or otherwise delegate Covered Services without Plan's prior written approval. Notwithstanding anything to the contrary, neither party may assign any of its rights and responsibilities under this Agreement to any person or entity without the prior written consent of the other party.

11.2.3 Nothing in this Agreement will permit Plan to assign or otherwise extend access to this Agreement or the rates set forth herein to any Affiliate of Plan (or its respective plan products), including without limitation, those entities that become Affiliates on or following the Effective Date.

11.2.4 As used in this Section 11.2, the term "assign" or "assignment" shall also include a change of control of a party by merger, consolidation, transfer, or the sale of thirty-three percent (33%) or more stock or other ownership interest in such party.

11.2.5 Any attempt by a party to assign its interest under this Agreement without complying with the terms of this paragraph shall be void and of no effect.

11.3 **Independent Contractor.** The relationship between Plan and Facility is solely that of independent contractors and nothing in this Agreement or otherwise shall be construed or deemed to create any other relationship, including one of employment, agency or joint venture.

Plan will notify Facility within thirty (30) days of any signed subcontractor or independent contractor agreement with any third party to provide services of any type that are covered under this Agreement. In the event that any portion of the services that Plan is responsible for hereunder are performed for or on behalf of Plan by a subcontractor or is delegated by Plan to a third party including but not limited to utilization management and radiology management, Plan shall be responsible for ensuring that such subcontractor or independent contractor furnishes such services in compliance with all of Plan's obligations under

this Agreement and the Regulatory Requirements. Notwithstanding any term to the contrary herein, Plan shall not delegate or subcontract the payment of Claims.

11.4 **Accounts Receivable Management Meetings.** On occasion and no more than bi-monthly, Facility may provide Plan with detailed accounts receivable aging by patient on Claims that are greater than sixty (60) days post discharge. Plan will respond with Claim level detail that includes the specific reasons for non-payment in a format acceptable to Facility within thirty (30) days of request. The parties will work diligently to resolve such outstanding accounts receivable.

11.5 **Name, Symbol and Service Mark.** During the term of this Agreement: (a) Plan may use Facility's name solely to make public reference to Facility as a Participating Provider or to include Facility's name in Participating Provider directories created and distributed by Plan; and (b) Facility may use Plan's name solely to make public reference to Plan as an organization, insurer, HMO or other type of MCO payor with whom Facility participates. Facility and Plan shall not otherwise use each other's name, symbol or service mark without prior written approval. During the term of this Agreement, Facility will be referenced as a Participating Provider in all Plan literature, electronic media, and provider directories for Managed Medicaid Plans covered under this Agreement.

11.6 **Confidentiality of Information.** Neither party shall disclose to third parties any confidential or proprietary business information which it receives from the other party, including, but not limited to, financial statements, business plans, protocols and programs; except that: (1) Facility may disclose information to a Member relating to the Member's treatment plan and the payment methodology; and (2) Plan may file the form of this Agreement with any federal or state regulatory entity as may be required by applicable law. Nothing in this provision shall be deemed to prohibit the parties from releasing confidential or proprietary information received from the other party if it is required in response to a valid subpoena or court order, or if it is necessary to provide the information to employees, officers or agents who have a need to know such information, and the parties shall ensure and warrant that such individuals have been informed of and agree to comply with the obligations in this provision. Notwithstanding anything to the contrary above, certain information regarding claims, eligibility, pre-authorization, coverage and reimbursement may be disclosed to Members or their representatives requesting such information.

11.7 **Entire Agreement.** This Agreement and any exhibits, attachments, addenda and amendments hereto constitutes the entire agreement between the parties in regard to its subject matter and supersedes any prior understandings and/or agreements between the parties, whether written or oral, with respect to the subject matter hereof.

11.8 **Facility Event.** In the event the Disclosed Agent by virtue of a sale, divestiture, closure, loss of lease or management contract, change to minority interest in joint-venture, etc. (a "Facility Event") no longer has the authority to contract on behalf of a Facility, then this Agreement shall become of no force or effect relative to such Facility as of the effective date of such Facility Event, except for those obligations incurred prior to the Facility Event, unless otherwise mutually agreed in writing by the Parties in order to accommodate a smooth transition through a divestiture. Notwithstanding the Facility Event, this Agreement shall remain in full

force and effect for all other Facilities listed on **Attachment C**. Facility will use commercially reasonable efforts to notify Plan not less than thirty (30) days prior to the occurrence of any Facility Event.

11.9 **Relationship.** References to the rights, responsibilities and obligations of Facility in the Agreement mean individually each of the facilities identified in **Attachment C**. Notwithstanding anything herein to the contrary, all such rights, responsibilities and obligations are individual and specific to such facilities and the reference to Facility herein in no way imposes any cross-guarantees or joint responsibility by, between or among such individual Facilities. Notwithstanding anything herein to the contrary, a breach or default by an individual Facility shall not constitute a breach or default by any other Facility. The Parties further agree that the responsibilities and obligations of Facility hereunder shall be the sole responsibility of such individual Facility and not that of the Disclosed Agent or any other individual Facility, or other Affiliate of Facility.

11.10 **No Incentives for Withholding of Care.** The parties acknowledge and agree that no provisions contained in the Agreement or any attachment provides incentives, monetary or otherwise, for the withholding of Medically Necessary care.

11.11 **No Waiver of Rights.** The waiver by either party of any breach of the other party of any provision of this Agreement shall not constitute a waiver of any subsequent breach of the same or different provision of this Agreement. Any waiver of any of the provisions of this Agreement shall be reduced to a writing and signed by both parties.

11.12 **No Third Party Beneficiaries.** Unless mandated by state or federal rules and regulations, there are no third party beneficiaries to this Agreement.

11.13 **Governing Law.** This Agreement shall be governed by and construed in accordance with the laws of the state in which the Facility is located (except to the extent pre-empted by federal law) without giving effect to its conflicts of laws principles.

11.14 **Severability**. If any part of this Agreement should be determined invalid, illegal, inoperative or contrary to law, such part shall be reformed, if possible, to conform to law; and in any event the remaining parts of this Agreement shall be fully effective and operative insofar as reasonably possible.

11.15 **Duplicate Originals**. This Agreement may be executed in one or more counterparts, each of which shall be deemed an original, but all of which constitute one and the same Agreement.

11.16 **Document Construction.** The parties agree that they have participated jointly in the negotiation and drafting of this Agreement (including the rates schedules set forth in **Attachment A** and the Managed Medicaid Plans designated in **Attachment B**, and have had access to legal counsel at all stages. In the event an ambiguity or question of intent or interpretation arises, this Agreement shall be construed as if drafted jointly by the parties, and no presumption or burden of proof shall arise favoring or disfavoring any party by virtue of the authorship of any provision(s) of this Agreement.

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

SELECT HEALTH OF SOUTH CAROLINA, INC.	**SOUTH ATLANTIC DIVISION, INC. as Disclosed Agent for those Facilities listed on Attachment C**
[INSERT: ADDRESS]	
Signature:	Signature:
Name:	Name:
Title:	Title:
Date:	Date:

Attachment A
Reimbursement

Plan agrees to reimburse Facility the reimbursement rates set out in the attached rate sheets, which are incorporated herein by reference, less any Member Expenses.

Attachment B

Managed Medicaid Plans & Corresponding Member Identification Cards

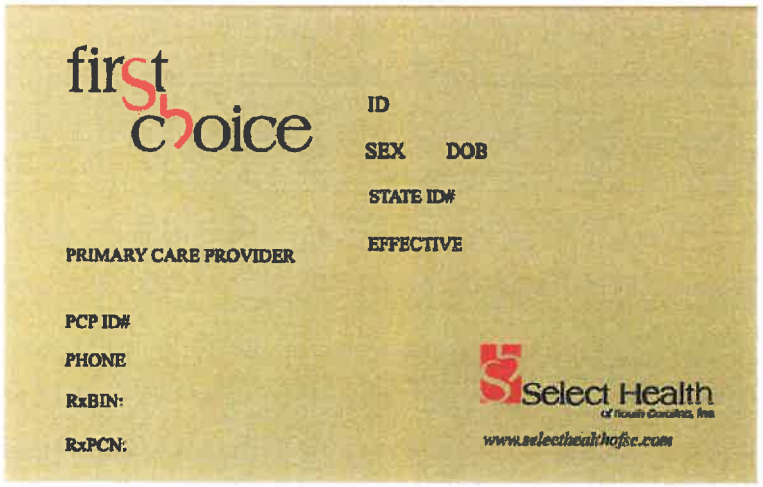
Subject to the provisions of this Agreement, Facility agrees to participate in the following Managed Medicaid Plans, as checked and initialed by both Parties:

First Choice by Select Health of South Carolina, Inc
First Choice Kids

The Plan shall forward to Facility proposed additions or deletions to the above list of Managed Medicaid Plans, together with the evidence of coverage, at least ninety (90) days prior to implementation of the new plan. If Facility agrees to the addition of the new plan in writing before its commencement, the Facility will be a Participating Provider in that Managed Medicaid Plan until the termination of the then current Term. The new plan's information shall be attached hereto as **Attachment B-1**, which shall be incorporated by reference herein.

Copies of sample Member identification cards for the above listed Managed Medicaid Plans are attached hereto and incorporated herein by reference. In the event Plan changes, replaces or modifies the Member identification cards used for the above listed Managed Medicaid Plans, Plan agrees to promptly provide Facility with a sample copy.

Front of card:



Back of card:

Members: 764-1877 in Charleston area or 1-888-276-2020 statewide. Call the Nurse Help line anytime day or night with your health questions - 1-800-304-5436.
Always carry your ID card and your Medicaid card. Always make sure your doctor is a First Choice provider. Go to an emergency room near you when you believe your medical condition may be an emergency. For all other non-emergency situations, call your primary care provider or our Member Services department

Providers: 764-1988 in Charleston area or 1-888-559-1010 statewide.
This card does not guarantee coverage or payment. Verify plan eligibility by calling First Choice, hecking the web site listed on the front of this card, or using the Medicaid eligibility system. Except for emergency care, some medical services require prior authorization. For admissions following emergency treatment, secure prior authorization within one business day following admission. Mail claims to: **P.O. Box 7120, London, KY 40742.**

Family planning services are not covered by First Choice, but are covered by Medicaid. Certain behavioral health and substance abuse initial assessment services are covered by First Choice and do not require prior authorization. Submit claims to Medicaid for all family planning and other mental health, alcohol and other drug (MH/AOD) abuse treatment services.

Pharmacy Prior Auth #: 1-866-610-2773
Pharmacy Claims Issues: 1-800-522-7487

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Part of the AmeriHealth Mercy family of companies. A healthcare ministry of the Sisters of Mercy.

Attachment C

Facility Locations

Attachment

Member Hold Harmless

STATE OF SOUTH CAROLINA
DEPARTMENT OF INSURANCE

HOLD HARMLESS AGREEMENT

In accordance with the requirements of Act No. 83 of 1987, and as a condition of participation as a health care provider in Select Health of South Carolina, Inc., the undersigned Provider (hereinafter "Provider") hereby agrees not to bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have recourse against, enrollees of Select Health of South Carolina, Inc., or persons acting on their behalf, for health care services which are rendered to such enrollees by Provider, and which are covered benefits under enrollees' evidence of coverage. This agreement extends to all covered health care services furnished to the enrollee during the time he is enrolled in, or otherwise entitled to benefits promised by, Select Health of South Carolina, Inc. This agreement further applies in all circumstances including, but not limited to, non-payment by Select Health of South Carolina, Inc. and insolvency of Select Health of South Carolina, Inc. This agreement shall not prohibit collection of copayments from enrollees by Provider in accordance with the terms of the evidence of coverage issued by Select Health of South Carolina, Inc. The Provider further agrees that this agreement shall be construed to be for the benefit of enrollees of Select Health of South Carolina, Inc., and that this agreement supersedes any oral or written contrary agreement now existing or hereafter entered into between the Provider and such enrollees, or persons acting on their behalf.

Provider's Name: _____

Signature: _____

Type Name: _____

Title (if applicable): _____

Date: _____

Form SCID 505

Document comparison done by DeltaView on Wednesday, October 28, 2009 6:18:43 PM

Input:	
Document 1	pcdocs://charleston/627140/4
Document 2	pcdocs://charleston/627140/7
Rendering set	Standard

Legend:	
Insertion	
~~Deletion~~	
~~Moved from~~	
Moved to	
Style change	
Format change	
~~Moved deletion~~	
Inserted cell	
Deleted cell	
Moved cell	
Split/Merged cell	
Padding cell	

Statistics:	
	Count
Insertions	39
Deletions	48
Moved from	2
Moved to	2
Style change	0
Format changed	0
Total changes	91

South Atlantic Division, Inc.-HCA Hospitals

1. Header information refer to the facilities listed in Attachment C, there are no facilities listed in Attachment C, please list all facilities.

2. Section 2.4 Claim; list both UB-92 and CMS 1450, please list current version of each.

3. Section 2.6 Covered Services; refers to Attachment A, in reviewing attachment A there is no list of covered services it is the reimbursement page, please complete the reimbursement page and correct this section.

4. Section 2.7 Emergency Medical Condition: Delete and replace with the definition that in the contract between Select and SCDHHS.

5. Section 2.8 Emergency Services: delete the following phrase" as determined by the emergency physician or provider actually treating the Member"; it is not part of the contract terms in the contract between Select and SCDHHS.

6. Section 2.14 Medicaid MCO Program; delete the phrase "and/or HIO"

7. Section 2.15 Medically Necessary: delete the following phrase "member as directed by the treating physician"; it is not part of the definition in the contract between SCDHHS and Select.

8. Section 2.17 Member Expense: delete the following phrase" including without limitation co-payments, coinsurance, deductibles, other cost-share amounts, and amounts for Non-Covered Services. The only member expense is co-pays and that is for adults only. Non-covered services must be address separately.

9. Section 2.18 Non-Covered Services: delete this section and use the definition in the contract between SCDHHS and Select.

10. Section 2.18 State Medicaid Agency Materials: P&P guide will changed effective October 1, 2009, please delete "July 1, 2009" current contract was effective April 1, 2008, this will be amended October 1, 2009

11. Section 4.3 Member Loss of Eligibility: delete the following phrase" Facility may collect from the Member any amounts for services rendered subsequent to the loss of coverage under the applicable Managed Medicaid Plan".

12. Section 4.4.10 delete the following sentences" For Members, SCDHHS will enroll newborns into the same managed care plan as the Member mother for the first ninety (90) calendar days from birth unless otherwise specified by the Member mother. The newborn will be enrolled in the same managed care plan as the Member mother through the end of the month in which the ninetieth (90^{th}) day falls. The newborn's effective date will be the first day of the month of birth. The newborn shall continue to be enrolled with the Member mother's Plan unless the mother/guardian changes the enrollment". Delete the following phrase "including indicating whether the mother is a Medicaid MCO Program Member".

13. Section 4.4.13 deletes the word "reasonable" and the phrase "not be an undue burden for Facility".

14. Section 4.7.1 current version will be posted on SCDHHS website, please update contract to reflect that requirement.

15. Section 4.7.2. delete all the words "reasonable" and the last phrase "which are not unduly burdensome to Facility".

16. Section 4.7.3 deletes the last phrase" Notwithstanding anything to the contrary, Plan Policies are guidelines, and as such shall not be incorporated as a term of this Agreement".

17. Section 4.8 delete "agrees to reasonably" add the word "shall"

18. Section 5.1 delete the following phrase" except that Facility may also seek payment from a Member for Member Expenses".

19. Section 5.8.1 delete entire section

20. Section 5.8.2 delete entire section.

21. Section 8.1 delete the phrase "shall use commercially reasonable efforts to" and insert "shall"

22. Section 8.1.1 deleted the phrase "use commercially reasonable efforts to"

23. Section 8.4 delete the following phrase" Subject to Facility's policies, procedures and bylaws"

In reading the contract I didn't read in the contract where it states that a member includes the patient, parents, guardian, spouse or any other legally responsible person of the member being served.

Also I did not read in the contract the specifying that the facility shall not assign any of its duties and/or responsibilities under this contract without the prior written consent of the Plan.

DEPARTMENT OF HEALTH AND HUMAN SERVICE
OFFICE OF DIRECTOR

→ Beverly

ACTION REFERRAL

TO	DATE
Myers / Hamilton / Singleton	11-20-09

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 001234	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR _____	[ ] Prepare reply for appropriate signature DATE DUE _____
	[ ] FOIA DATE DUE _____
	[X] Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			
2.			
3.			
4.			

JAN - NEED COPIES FOR DEIRDRA + NIKOLE + BEV

I meet w/ them Monday 30th

LOG INTO ME + BEV + Deirdra

See if I can get a mtg w/ Bev Tim H. + Robert Smith + Nikole tomorrow.

Timeline SCDHHS and the South Atlantic Division contract:

September 23, 2009- Peggy Vickery send South Atlantic Division contract to David Smith for review. David forwards the contract to Tim Hartnett on the same day.

September 28, 2009-Tim Hartnett sends Peggy Vickery the review of the reasons for denying the South Atlantic Division contract.

October 7th, Lisa Thomas leaves a voice message for David Smith asking him to return her call concerning the South Atlantic Division Contract.

October 8, 2009 David Smith and Tim Hartnett return the call to Lisa Thomas left her a message informing her that any questions she has about the denial should be addressed to Peggy Vickery at Select as the contract is between South Atlantic Division and Select Health. The only role SCDHHS play is to review the submitted contract for compliance.

October 9, 2009 Callie Campbell calls Jennifer Campbell requesting information on the South Atlantic Contract denial. Jennifer forwards the call to Larry Fernandez, Tim Hartnett, Jim Bradford, Jennifer Campbell and Jim Bradford call Callie Campbell. Ms. Campbell told us she worked for Haynsworth Sinkler and Boyd but would not tell us who her client was or how she had access to confidential contract amendments when the information was not available to the general public.

HCA

Hospital Corporation of America

South Atlantic Division
900 Island Park Drive, Suite 202A
Daniel Island, SC 29492

Phone 843 647-4010
Fax 843 216-5984

November 16, 2009

Felicity Costin Myers, Ph.D
Deputy Director of Medical Services
Department of Health & Human Services
1801 Main Street
11th Floor
Columbia, SC 29201

Re: Approval of Select Health's Participation Agreement with South Atlantic Division, Inc.

Dear Ms. Myers:

The South Atlantic Division, Inc. ("South Atlantic"), an HCA affiliate, which contracts on behalf of HCA Hospitals in South Carolina, specifically Trident Regional Medical Center, Colleton Medical Center, Grand Strand Regional Medical Center as well as other HCA facilities (the "HCA Facilities"), has been in contract negotiations with Select Health of South Carolina, Inc. ("Select Health"). The HCA Facilities have participated in Select Health's Medicaid Managed Care Program for a number of years. Recently, Select Health and South Atlantic entered into a renegotiation of their existing agreement. Select Health and South Atlantic reached a satisfactory agreement, which attorneys for both parties believed complied with South Carolina law, the South Carolina Department of Health and Human Services ("DHHS") April 2008 Model Contract for managed care organizations (the "Model Contract") and the DHHS April, 2008 Policy and Procedure Guide for Managed Care Organizations, as posted on its website (the "Guide").

Select Health presented to DHHS a Participation Agreement with a regulatory addendum designed to satisfy the then current DHHS model contract requirements the Guide. Our attorneys believe that this format has been approved by DHHS in the recent past. DHHS, however, rejected the Participation Agreement and Regulatory Addendum and insisted that the parties enter into an agreement with no regulatory addendum. In an effort to comply with DHHS's request, the provisions of the regulatory addendum were incorporated into the base agreement, which was again sent to DHHS for approval. Once again, DHHS disapproved the agreement.

The basis for the second rejection is set forth in the attached document, which we understand was prepared by Tim Hartnett with assistance from David Smith. (See Exhibit "A"). DHHS's objections to the contract fall into several categories:

- The first category of changes involves negotiated changes between Select Health and South Atlantic regarding Select Health's policies and procedures. For example, the parties had agreed that Select Health's policies and procedures were not incorporated into the Agreement. (The parties have agreed that they will comply with all DHHS policies and procedures and incorporated DHHS policies where required.) Plans desire to unilaterally amend their policies and procedures and often do so in a manner that is adverse to the interest of the provider. The proposed deletion of these provisions interferes unreasonably with the relationship between Select Health and South Atlantic, and we request reconsideration of DHHS's position in this regard.

- Second, DHHS rejected many provisions because the syntax or order of words of a sentence did not exactly match the syntax or order of words contained in the model agreement. In addition, the parties had added language, consistent with the Guide and federal law that were not in the Model Contract. DHHS required the additional language to be deleted. South Atlantic and Select Health will agree to make those changes and they are set forth in the attached redlined agreement. (See Exhibit "B"). South Atlantic, however, requests that DHHS reconsider its rejection of the language related to the definitions of "Emergency Medical Condition" and "Medically Necessary." The additional language regarding the application of the definition of Emergency Medical Condition to pregnant women is designed to comply with the Emergency Medical Treatment and Active Labor Act ("EMTALA") and Section 4.3 of the Model Contract. The addition of this language is not prohibited by state or federal law, the Guide or the Model Contract. Rather, it is designed to clarify Select Health's obligations to cover Emergency Services provided to this vulnerable population. Further the language ensures that the determination of whether the Emergency Medical Condition exists remains with the treating physician. This is consistent with Section 4.3 of the Model Contract and EMTALA and better protects the Member. Select Health agreed with this language. We are unable to discern why DHHS would require the language to be deleted as it is lawful and consistent with the Guide.

- The third category of changes involves the deletion of any provision that permitted the HCA Facilities to collect any Member co-payment or to charge the member for Non-Covered Services. South Atlantic appreciates DHHS's efforts to protect its Members, and is willing to accept DHHS's changes with regard to the definition of Covered Services. However, many of the other requested changes would limit South Atlantic's rights, which are clearly protected by law. The Select Health Model Agreement, the Guide and South Carolina state law all permit a healthcare provider to collect non-covered expenses from a member of the Medicaid Managed Care Program. S.C. Code Ann. §38-33-130; Model Contract § 13.27. Further, federal law permits, as does the Model Contract,

limited co-payments for adult members over the age of 19. Model Contract Section 2.3. On the other hand, DHHS insists that Select Health and South Atlantic delete the Section 5.8.2, which would have permitted the HCA Facilities to waive a co-payment, for example, under its charitable care policies, a provision that benefits Members.

It is our contention that DHHS's insistence that the parties remove these provisions unreasonably interferes with Select Health's and South Atlantic's negotiated agreement. Given that Select Health has accepted a risk-based contract with DHHS, we question DHHS's reasoning for requiring such deletions to the agreement, when the underlying provisions are clearly permitted by law and not contrary to the Guide or the Model Contract. DHHS has provided us with no reasoning or basis for its disapproval of these provisions. While, at this time, Select Health's plan design does not require Member copayments (even though permitted by DHHS), it may do so in the future, with DHHS approval. Because the parties intend this Agreement to survive Plan changes, we respectfully request the language, as revised, be approved.

- Finally, in a number of places, Mr. Hartnett was unable to locate provisions required by the Model Contract that are, in fact, included in both the first and second agreements. Similarly, Mr. Hartnett has requested that the references to the Guide be changed to reflect an October 1, 2009 update. We would note this update was not posted or publicly available on the DHHS website as late as October 7, 2009. DHHS subsequently posted an "informational" draft on the website, with the disclaimer that it is pending CMS approval. The proposed agreement clearly acknowledges that DHHS policies and procedures may be updated from time to time and incorporates any such updates by reference. Accordingly, we believe these requested changes are unnecessary and may be confusing if the final update is never posted, posted with a different date, or ultimately not approved by CMS.

In an effort to work through these issues with DHHS, our attorney called Mr. Smith who had forwarded DHHS's comments to Ms. Peggy Vickery with Select Health, who in turn forwarded them to South Atlantic. Mr. Smith and Mr. Hartnett returned our attorney's call, but were not willing to discuss DHHS's comments requesting that any changes be communicated through Select Health. Because Select Health has interests that are counter to the provider, it is inappropriate for Select Health to independently negotiate changes to the Agreement that will potentially impact South Atlantic in an adverse manner. DHHS's unwillingness to discuss its requested changes to the Agreement gives the Plans an unfair competitive advantage over the providers at a time when Select Health's denial rate is running at approximately 10%. After having negotiated a contract with Select Health, South Atlantic's efforts to move forward to address and discuss DHHS's comments are completely stalled by DHHS's unwillingness to discuss its position and reasonably negotiate the necessary changes.

Thank you for agreeing to meet with me on Monday, November 23rd. I look forward to meeting you and working together to resolve these matters.

Sincerely,

Rodney Van Pelt
Chief Financial Officer
South Atlantic Division

~~09/03/09 Redline from Facility~~
~~Blended Document: Blends Regulatory Requirements into Base Agreement~~**MANAGED MEDICAID**
FACILITY PARTICIPATION AGREEMENT

This Facility Participation Agreement ("**Agreement**") is executed by and between **Select Health of South Carolina, Inc.** ("**Plan**") and **South Atlantic Division, Inc.** as disclosed agent (the "**Disclosed Agent**") on behalf of those facilities identified in **Attachment C**, which is attached hereto and made a part hereof (each referred to herein individually as "**Facility**" whether or not licensed as a general acute care facility), and is effective as of _____, 2009 (the "Effective Date").

SECTION 1

RECITALS

1.1 Plan is a South Carolina licensed Health Maintenance Organization ("HMO") that is approved and operated as a Medicaid Managed Care Entity as defined at Section 1932 of the Social Security Act and applicable regulations.

1.2 Plan has contracted to assist the South Carolina Department of Health and Human Services ("**SCDHHS**") in the purchase and provision of healthcare services under the South Carolina Medicaid Managed Care Organization ("MCO") Program, and seeks to delegate to Facility the provision of healthcare services included in the South Carolina State Medicaid Plan ("**Covered Services**") to Medicaid MCO Program members.

1.3 Facility is licensed and duly authorized in the State of South Carolina to provide healthcare services and seeks to provide Covered Services to Medicaid MCO Program members in exchange for payment by the Plan for services rendered.

1.4 Plan and Facility desire to enter into this Agreement setting forth the rights and responsibilities of the parties with respect to the provision of Covered Services to Medicaid MCO Program members and in accordance with the Medicaid MCO Contract, as applicable to Plan, any applicable State Medicaid Agency Manuals applicable to Plan or Facility, and all applicable State and federal laws and regulations as applicable to this Agreement.

SECTION 2

DEFINITIONS

2.1 **Affiliate**. An entity controlled by, controlling, or under common control with another entity including, but not limited to, through ownership of stock, joint venture, membership interest, or a management contract. For purposes of this definition, "control" of an entity means direct or indirect ownership of a majority of the entity.

2.2 **Billed Charges.** The total charges for services rendered by Facility as set forth in the Facility's internally established charge master in effect on the date the services are rendered,

considered Facility's usual and customary charges; such charges are not dependent upon a governmental or payor fee schedule.

2.3 **Clean Claim.** A Claim that can be processed without obtaining additional information from the provider of the service or from a third party.

2.4 **Claim.** A paper or electronic billing instrument that consists of a complete UB-~~92~~04 or CMS ~~1450~~,1500, as applicable, data set, or their respective successor forms, with entries stated as mandatory by the National Uniform Billing Committee, and with respect to electronic claim forms, completed in the format and with the data content and data conditions specified in HIPAA.

2.5 **CMS.** The federal Centers for Medicare and Medicaid Services (formerly known as the Health Care Financing Administration).

2.6 **Covered Services.** Services included in the South Carolina State Medicaid Plan and as set forth in Attachment A hereto.

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

~~(a) Serious jeopardy to the health of a patient, including a pregnant woman or a fetus.~~

~~(b) Serious impairment to bodily functions.~~

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

With respect to pregnant women, an emergency medical includes, but not limited to, condition when there is:

(a) Inadequate time to effect safe transfer to another facility prior to delivery.

(b) Transfer may pose a threat to the health and safety of the patient or fetus.

(c) Evidence of onset of uterine contractions or rupture of the membranes.

2.8 **Emergency Services**. Covered inpatient and outpatient services that are as follows: (1) furnished by a provider that is qualified to furnish these services; and (2) needed to evaluate or stabilize an Emergency Medical Condition, as determined by the emergency physician or provider actually treating the Member.

2.9 **EPSDT.** An Early and Periodic Screening, Diagnosis and Treatment Program mandated by Title XIX of the Social Security Act.

2.10 **Federally Qualified Health Center ("FQHC").** A South Carolina licensed health center certified by the CMS that receives Public Health Services grants. A FQHC is eligible for state defined cost based reimbursement from the Medicaid fee-for-service program. A FQHC provides a wide range of primary care and enhanced services in a medically underserved area.

2.11 **HIPAA.** Health Insurance Portability and Accountability Act of 1996, and the rules and regulations promulgated thereunder, each as may be amended from time to time.

2.12 **Medicaid MCO Contract.** The contract between Plan and SCDHHS.

2.13 **Managed Medicaid Plan.** A health benefit design or product, offered and issued by Plan pursuant to the Medicaid MCO Contract, that contains the terms and conditions of a Member's coverage, under which the Member and Plan are obligated to pay for Covered Services and under which Facility is a Participating Provider pursuant to the terms of this Agreement.

2.14 **Medicaid MCO Program.** The South Carolina Medicaid managed care program regulated, operated and administered by CMS~~,~~ or SCDHHS~~ and/or an HIO~~, pursuant to Sections 1902(a)(4), 1903(m), 1905(t), and 1932 of the Social Security Act and for which an **Attachment A** is incorporated into this Agreement setting forth the Facility's reimbursement for the Program.

2.15 **Medically Necessary.** Those medical services which: (i) are essential to prevent, diagnose, prevent the worsening of, alleviate, correct or cure medical conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or aggravate a handicap, or result in illness or infirmity of a Medicaid MCO Program member as directed by the treating physician; (ii) are provided at an appropriate facility and at the appropriate level of care for the treatment of Medicaid MCO Program member's medical condition; and, (iii) are provided in accordance with generally accepted standards of medical practice.

Plan agrees, by law, that what constitutes medically necessary services (i) may be no more restrictive than that used in the Medicaid MCO Program as indicated in State statutes and regulations and other State policy and procedures and (ii) must address the extent to which the Plan is responsible for covering services related to the following: (a) the prevention, diagnosis, and treatment of health impairments; (b) the ability to achieve age-appropriate growth and development; and (c) the ability to attain, maintain, or regain functional capacity.

2.16 **Member.** An individual who is an eligible Medicaid MCO Program beneficiary and who is voluntarily enrolled as a Plan member in accordance with requirements of the applicable Medicaid MCO Program.

2.17 **Member Expenses.** Any amounts that are the Member's responsibility to pay a health care provider or professional pursuant to the Member's Medicaid MCO Plan, including without limitation co-payments, ~~coinsurance, deductibles, other cost-share amounts, and amounts for Non-Covered Services~~if permitted by the Managed Medicaid Plan.

2.18 **Non-Covered Services.** Services not covered under the Title XIX SC State Medicaid Plan~~ and services that are not Covered Services a defined herein, including, but not limited to,~~

~~those services denied as not Medically Necessary, services de-certified and those services not authorized~~.

2.19 **Participating Facility.** A facility which has entered into a direct written agreement with Plan to provide Covered Services.

2.20 **Participating Provider.** A health care professional, provider or facility, including but not limited to a physician, home health agency, hospital, ambulatory surgery center, laboratory or other professional, facility, supplier, or vendor that has entered into a written agreement with Plan, directly or through one or more other entities, to provide Covered Services to all or some Members.

2.21 **Post-Stabilization Services.** Covered Services, including emergency admissions related to an Emergency Medical Condition, that are provided after a Member is stabilized in order to maintain the stabilized condition, or improve or resolve the Member's condition.

2.22 **Primary Care Provider or PCP.** The provider who serves as the entry point into the health care system for the Member. The PCP is responsible for including, but not limited to providing primary care, coordinating and monitoring referrals to specialist care, authorizing hospital Covered Services, and maintaining the continuity of care.

2.23 **Receipt.** The initial receipt of a Claim submitted by Facility for services rendered to Members, i.e., the initial receipt of a Claim by Plan. There shall be a rebuttable presumption that a Claim has been received by the party to whom it was transmitted within (i) three (3) business days following the date Facility placed the Claim in the United States mail for Claims submitted by paper, or (ii) the date verified by the 277 transaction set A-2 status code for Claims submitted electronically. The date of the receipt of the Claim is the date the Plan receives the Claim, as indicated by the date stamped on the Claim. The date of payment is the date of the check or other form of payment.

2.24 **Regulatory Requirements**. Any requirements imposed by applicable federal or state rules and regulations imposed pursuant to a Medicaid MCO Contract, or in connection with the operation of the Medicaid MCO Program which are considered mandatory on Facilities and which can not be modified by contract.

2.25 **Service Area**. The geographic area in which eligible Medicaid MCO Program members may be accepted for enrollment into the Plan. The Service Area must be approved by the South Carolina Department of Insurance ("SCDOI").

2.26 **State**. The state of South Carolina.

2.27 **State Agency**. The South Carolina Department of Health and Human Services and any instrumentality thereof.

2.28 **State Medicaid Agency Materials**. SCDHHS's policy and procedure manual applicable to the South Carolina Medicaid MCO Program and available in writing or electronically on the SCDHHS website, including (i) the South Carolina Policy and Procedure Guide for Managed Care Organization effective April 2008, as may be updated from time to time

(the "Guide") and (ii) the model contract between SCDHHS and 2008 Managed Care Providers dated as of July 1, 2009 (the "Model Contract"). SCDHHS "policies" are the general principles by which SCDHHS is guided in its management of the Medicaid MCO program, as further defined by SCDHHS promulgations and by state federal rules and regulations.

SECTION 3

SCOPE OF AGREEMENT

3.1 **Accessibility.** This Agreement applies to those Facilities set forth in **Attachment C** and the Managed Medicaid Plans set forth in **Attachment B**. During the term of this Agreement, Facility agrees to be a Participating Provider, and Plan agrees to pay Facility for Covered Services provided pursuant to the terms of this Agreement at the rates set forth in **Attachment A** which rates shall apply to inpatient discharge dates and outpatient service dates which occur on or following the Effective Date. The parties agree that this Agreement is a full service agreement allowing for access to and payment for both inpatient and outpatient care, services and technology available at and offered by Facility for all Members on the same basis and through the same referral and approval process as Plan uses with other Participating Providers.

3.2 **Credentialing**. Plan shall credential Facility and all Participating Providers providing services hereunder using nationally recognized criteria. Plan will work diligently to credential physicians who are on Facility's medical staff (provided such physicians meet the credentialing criteria referenced above), and new Facilities that become Participating Providers during the term of this Agreement.

3.3 **Physician Access.** Plan will not in any way discourage Members or Participating Providers from being able to access Facility for any service that is performed or made available by Facility.

3.4 **Consistent Criteria.** Plan, including any third party acting on Plan's behalf, will not disadvantage Facility in relation to other Participating Facilities or Participating Providers through the use of preferential Member Expenses. Plan and any third party acting on Plan's behalf, will apply its criteria authorizing services and approving referrals consistently to all Participating Providers.

3.5 **Proprietary Rate Information.** Plan agrees not to sell, broker or share rate information or provide it to any third party except as required by any governmental agency or as otherwise required by law.

3.6 **Addition of New Medicaid MCO Plans.** Notwithstanding anything to the contrary in this Agreement, the parties must mutually agree in writing to the addition of new or modified Medicaid MCO Plan product offerings and applicable reimbursement rates associated with these new product offerings.

SECTION 4

DUTIES OF FACILITY AND PLAN

4.1 **Identification Cards.** Plan shall provide Members with a unique identification card. Plan will provide Facility with specimen identification cards used by Members for Managed Medicaid Plans covered under this Agreement to enable Facility to initially verify a patient's access to the Plan discount. A listing of all Participating Providers, including without limitation Facility, will be made available by Plan to Members. Members must present their identification cards at the time of registration or receipt of services upon each inpatient or outpatient encounter. The parties agree that Facility shall be entitled to rely upon the accuracy of the information contained on the card presented.

4.2 **Eligibility Verification.** Plan shall maintain telephone and/or electronic or online services twenty-four (24) hours a day, three hundred sixty five (365) days per year for purposes of allowing Participating Providers to confirm Member eligibility. Plan shall respond to all requests for eligibility determination within four (4) hours following such request. Plan shall notify Facility of other additional means made available to Participating Providers to verify Member eligibility as they become available.

4.3 **Member Loss of Eligibility.** For a Member whose request for Facility services was authorized, and who later becomes ineligible for Plan benefits due to enrollment in another Medicaid Managed Care Plan, Plan must notify Facility within thirty (30) days of inpatient discharge or outpatient date of service that the Member became ineligible. Plan may request a refund of amounts paid for that Member within the above referenced thirty (30) day timeframe, regardless of any alternative time periods provided for under Section 5 of this Agreement. However, if Member returns to coverage under traditional Medicaid fee for service, Plan may request a refund of amounts paid so long as the Medicaid claims filing deadline has not expired, regardless of any alternative time periods provided for under Section 5 of this Agreement. If permitted by Regulatory Requirements, Facility may collect from the Member any amounts for services rendered subsequent to the loss of coverage under the applicable Managed Medicaid Plan unless the Member subsequently qualifies for Medicaid fee for service.

4.4 **Provision of Services.** Facility agrees to provide inpatient and outpatient health care services which Facility makes available to the public to Members in the same manner as provided to other patients and without regard to race, religion, gender, color, national origin, age, source of payment, the type of Managed Medicaid Plan under which the Member has coverage, or physical or mental health status. Plan shall provide services to Members in the same manner as Plan provides those services to Plan's commercial members. The services shall be as accessible to Members as they are for non-Members residing in the same Service Area.

4.4.1 Facility shall provide Covered Services to Members through the last day that this Agreement is in effect and in accordance with the Medicaid MCO Program and the Regulatory Requirements.

4.4.2 Facility shall not refuse to provide Medically Necessary or preventive Covered Services to Members covered under the Medicaid MCO Contract for non-medical reasons.

4.4.3 Plan acknowledges not all Covered Services are available on a 24 hour per day, 7 days per week basis (e.g. cardiac catheterization laboratory, outpatient surgery, certain diagnostic testing, etc.) Accordingly, Plan will not deny Claims or otherwise penalize Facility for services

that are not made available and provided to Members on a 24 hour per day, 7 days per week basis consistent with standards of like facilities in the community.

4.4.4 In cases in which Facility, Plan or a treating physician determines that Emergency Services are required for a Member or instructs that such services be provided to a Member, Facility shall provide such services as are necessary to evaluate, and if necessary, treat to stabilize the condition of the Member without prior approval from Plan, as required by the Regulatory Requirements. Plan shall pay for Emergency Service in accordance with **Attachment A**.

4.4.5 Regardless of any provision to the contrary, Facility, at its sole discretion, may elect at any time during the term of this Agreement to discontinue any type of service at the Facility, provided that such discontinuation shall be as to the general public and not solely as to Plan Members.

4.4.6 Facility agrees to meet State standards for timely access to care and services, taking into account the urgency of the need for services.

4.4.7 Appointment waiting times shall not exceed the following requirements:

- Routine visits scheduled within four (4) to six (6) weeks;
- Urgent, non-emergency visits within forty-eight (48) hours; and
- Emergent or emergency visits immediately upon presentation at a service delivery site;
- Waiting times should not exceed forty-five (45) minutes for scheduled appointment of a routine nature.

Walk-in patients with non-urgent needs should be seen if possible or scheduled for an appointment consistent with written scheduling procedures. Walk-in patient with urgent needs should be seen within forty-eight hours. Facility shall not use discriminatory practices with regard to Members such as separate waiting rooms, separate appointment days, or preference to private pay patients

4.4.8 Facility shall monitor the quality of Covered Services delivered under this 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 Facility operates and/or the standards established by SCDHHS or its designee.

4.4.9 Plan shall permit female enrollees thirteen (13) years of age and older two (2) visits annually without prior referral to the health care services of an obstetrician/gynecologist in the Plan network. Plan's health maintenance organization plans must authorize medically necessary services referred by the obstetrician/gynecologist during these two visits per calendar year without requiring the additional referral of the patient's PCP. S.C. Code Ann. § 38-33-325.3.4.7

4.4.10 All newborns of Members are the responsibility of Plan, unless the Member mother has specified otherwise prior to delivery or SCDHHS does not enroll the newborn into the Plan. To assure continuity of care, Plan shall make every effort to expedite enrollment of newborns into the Member mother's Plan. ~~For Members, SCDHHS will enroll newborns into the same managed care plan as the Member mother for the first ninety (90) calendar days from birth unless otherwise specified by the Member mother. The newborn will be enrolled in the same managed care plan as the Member mother through the end of the month in which the ninetieth (90th) day falls. The newborn's effective date will be the first day of the month of birth. The newborn shall continue to be enrolled with the Member mother's Plan unless the mother/guardian changes the enrollment.~~ Plan shall inform Facility and the newborn's attending and consulting physicians that the newborn is a Plan Member and that Facility should seek reimbursement from Plan. Facility shall notify Plan and SCDHHS of births when the mother is a Medicaid MCO Program Member. Facility shall complete the SCDHHS Request for Medicaid ID Number (Form 1716 ME), ~~including indicating whether the mother is a Medicaid MCO Program Member,~~ ~~and submitting~~and submit the form to the local SCDHHS/State SCDHHS office~~.~~

4.4.11 In accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et. seq.) (2001, as amended) and its implementing regulation at 45 C.F.R. Part 80 (2001, as amended), Facility shall take adequate steps to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and Covered Services provided under this Agreement.

4.4.12 Facility and Plan agree that nothing in this Agreement shall be construed to limit Facility's ability to discuss with a Member the treatment options available to that Member, risks associated with treatments, case management/utilization management decisions, or recommended course of treatment, and nothing in this Agreement shall limit Facility's legal obligations to a Member as specified under the Facility's professional license. However, nothing in this section shall prevent Plan from prohibiting disclosure of trade secrets by Facility. S.C. Code Ann. § 38-71-1740(a)(2).

4.4.13 Facility shall submit all reports and clinical information ~~reasonably~~/ required by the Plan, which submission of reports and clinical information shall not be an undue burden for Facility, including EPSDT (if applicable).

4.5 **Notification of Services.**

4.5.1 Facility will notify Plan of the presentation of a Member to Facility within twenty-four (24) hours or the end of the next business day, whichever is less, of the presentation or the end of the next business day, whichever is greater.

4.5.2 Plan will issue an authorization number within twenty-four (24) hours or the end of the next business day, whichever is less, upon notification that reflects Covered Services from the date of Member's presentation through the date of discharge and physician orders as they relate to patient type (i.e. admission vs. observation) with confirmation by facsimile transmission.

4.5.3 Requests for treatment authorization after notification cannot be held pending for more than twenty-four (24) hours.

4.5.4 Regardless of any provision in this Agreement or Plan policy or procedure to the contrary, in the case of an emergency, Facility is not required to provide notice, obtain coverage verification or prior authorization from Plan prior to providing Emergency Services and Post-Stabilization Services subsequent to a Member inpatient admission.

4.5.5 Where Covered Services were previously authorized by the Plan, payment for those services cannot be retrospectively denied for any reason, other than as described in Section 4.3 for patients who are no longer eligible as Members.

4.6 **Discharge Planning Guidelines.**

4.6.1 Plan will perform continuing inpatient clinical review, actively participate in discharge planning, and will coordinate the physician ordered placement for SNF, DME or home health services with Plan vendors and other Participating Providers, issue the appropriate authorizations to the vendors and communicate same to Facility case management departments via facsimile, electronic or online transmission, or telephone to a pre-designated phone number.

4.6.2 Plan will not deny stays or portions of stays and shall reimburse Facility according to **Attachment A** when Plan reviewers are not available for coordination of discharge plans and cannot find appropriate placement post discharge thus creating discharge delays or when the Member's treating physician creates discharge delays.

4.7 **Plan Policies.** Subject to Facility's policies and bylaws, Facility shall reasonably cooperate with Plan's quality assurance, quality improvement, member grievance and appeal, medical records retention and credentialing criteria policies (the "Plan Policies"), provided that such Plan Policies have been provided to the Facility sixty (60) days in advance of their effective date and Plan has made any reasonable modifications to such Plan Policies that are requested by Facility. Plan Policies shall be consistent with the terms of this Agreement, with Facility's policies and procedures, and with applicable law; commercially reasonable; in writing; and changes thereto will be noticed in writing.

4.7.1 The SCDHHS's policy and procedure manual applicable to the South Carolina Medicaid MCO Program is available in writing or electronically on the SCDHHS website, including (i) the South Carolina Policy and Procedure Guide for Managed Care Organization effective April, 2008, as may be updated from time to time (the "Guide") and (ii) the model contract between SCDHHS and 2008 Managed Care Providers dated as of April 1, 2008 (the "Model Contract"). SCDHHS "policies" are the general principles by which SCDHHS is guided in its management of the Medicaid MCO program, as further defined by SCDHHS promulgations and by state federal rules and regulations. Guide, Definition of Terms, p. 177 (for definition of "Policies").

4.7.2 Further, Facility shall adhere to the ~~reasonable~~ Quality Assessment Performance Improvement ("QAPI") and Utilization Management ("UM") requirements as outlined in the State of South Carolina Medicaid Managed Care Program Policy and Procedure Guide as applicable to Facility. The QAPI and UM Requirements shall be included as part of the

Agreement. Facility shall comply with any reasonable plan of correction initiated by Plan and/or any plan of correction required by SCDHHS. Whether announced or unannounced, Facility shall participate and cooperate in any internal and external reasonable quality assurance review, utilization review, peer review and grievance procedures established by Plan and/or SCDHHS or its designee ~~which~~, so long as the Plan procedures are not unduly burdensome to Facility.

4.7.3 Plan shall provide at least sixty (60) days, or such lesser period of time as may be required by the State Agency, prior written notice to Facility of any modifications to such Plan Policies during the term of this Agreement. Facility agrees to communicate to Plan any inquiries, issues or objections to the above referenced modifications to Plan Policies within the above referenced notice period. Plan shall respond to Facility communications related to such policies in a timely manner. Notwithstanding anything to the contrary, Plan Policies are guidelines, and as such shall not be incorporated as a term of this Agreement.

4.7.4 Plan agrees to provide Facility with instruction as to its authorization procedure(s) for Participating Facilities, to use when verifying eligibility and coverage of Members and/or when seeking pre-authorization for services.

4.7.5 Regardless of any past, present or future provision, policy, procedure, methodology, rule, manual, guideline, UR criteria or other data/document/process, and/or any change therein, to the contrary, Plan may not unilaterally change, reduce, modify or otherwise adjust downward the reimbursement set out in this Agreement.

4.7.6 Plan agrees that by law it may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the Member.

4.7.7 Plan agrees that it must provide written notification to Facility and give the Member written notice of any decision by the Plan to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested, and that such notice must comply with applicable state and federal rules and regulations and Medicaid MCO Program requirements.

4.7.8 Plan agrees that it must, by law, compensate individuals or entities that conduct utilization management activities so that payment is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary services to any Member.

4.7.9 Plan shall maintain an organized, integrated Member services function to assist Members in understanding Plan's policies and procedures. Plan's Member services function should provide additional information about the Plan's Primary Care Providers, facilitate referrals and assist in the resolution of service and/or medical delivery concerns or problems a Member may have. The Plan shall identify and educate Members who access the system inappropriately and provide Members additional education as needed.

4.8 **Member Grievances.** Facility ~~agrees to reasonably~~shall cooperate with Plan in identifying and resolving Member complaints and grievances pursuant to the grievance procedures of Plan, except to the extent Facility would be required to admit legal liability, waive

an existing or potential legal claim, or waive a right under this Agreement. Plan shall provide a written report that identifies the Member or Facility grievance and/or complaint, action taken and outcome. Plan shall make available to Facility a copy of the Plan Member handbook through the Plan website or by providing a physical copy upon request.

4.9 **Facility Based Providers.** Facility may employ or contract with certain Facility-based providers such as emergency room physicians, pathologists, radiologists, anesthesiologists, neonatologists, certified registered nurse anesthetists ("CRNAs") and intensivists.

4.9.1 Subject to any legal or administrative restrictions and in accordance with Facility's policies, procedures and bylaws, Facility agrees to provide Plan with information regarding such Facility-based providers' clinical privileges at Facility.

4.9.2 If Plan is unable to obtain participation agreements with such Facility-based providers rendering services at Facility, Facility agrees to assist Plan with introductory meetings.

4.9.3 The parties agree that reimbursement for professional services rendered to Members by such Facility-based providers is not covered by this Agreement and shall be billed independently by such providers.

4.10 **Regulatory Requirements.** Notwithstanding any other statement in this Agreement or its attachments to the contrary, Plan and Facility acknowledge and agree that this Agreement is subject to applicable Regulatory Requirements in effect as of the Effective Date.

4.11 **Advance Directives.** The parties agree to comply with the Patient Self-Determination Act and other state and federal laws, rules and regulations regarding patient advance directives, as they may be amended from time to time and to the extent applicable.

4.12 **Rate Load.** Plan agrees to load the reimbursement rates herein into its claims processing system prior to the Effective Date of this Agreement. Each party shall designate a representative to address issues associated with processing Claims. Plan agrees to provide reasonable on-site and electronic access to Facility's representatives to verify that reimbursement rates have been accurately loaded. In addition, Plan agrees to provide Facility with printouts of the rates actually loaded into the Plan's claims processing system within thirty (30) days after the Effective Date and within thirty (30) days of any amendments to the rates.

4.13 **Plan Confirmation of Member Expense Obligation.** Upon request of Facility, Plan will provide Facility with a letter on Plan letterhead that states that it is the Facility's right to collect and the Member's responsibility to pay Member Expenses at the time of service.

4.14 **Adequate Network**. Plan shall maintain an adequate network of Participating Providers to provide coverage to Members. Plan shall at a minimum contract with at least one tertiary care center in the Service Area for each of the following: (i) Neonatal services and Perinatal services; (ii) Pediatric services; (iv) Trauma Services; (v) Burn Services and (vi) adequate facilities for post discharge services.

4.15 **Conflict of Interest**. Facility represents and covenants that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or

degree with the performance of its services hereunder. The Facility further covenants that, in the performance of the Agreement, no person having any such known interests shall be employed.

4.16 **Provider Bill of Rights**. Plan shall abide by the following Provider Bill of Rights adopted by SCDHHS:

4.16.1 Plan shall provide information on the Grievance, Appeal and Fair Hearing procedures.

4.16.2 Plan shall provide access to its policies and procedures covering the authorization of services.

4.16.3 Plan shall notify Facility of any decision by Plan to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.

4.16.4 Plan shall permit Facility to challenge, on behalf of the Medicaid Plan Members, the denial of coverage of, or payment for, medical assistance.

4.16.5 Plan's provider selection policies and procedures will not discriminate against Facility on the basis that it serves high-risk populations or specializes in conditions that require costly treatment.

4.16.6 Plan shall not discriminate against Facility with respect to the participation, reimbursement, or indemnification of Facility so long as Facility is acting within the scope of its license or certification under applicable State law, solely on the basis of that license or certification.

4.16.7 A health care professional, acting within the lawful scope of practice, shall not be prohibited from advising or advocating on behalf of a Member who is his/her patient, for the following:

- The health status of the Member or medical care or treatment options for the Member's condition or disease, including any alternative treatment that may be self-administered, regardless of whether benefits for such care or treatment are provided under this Agreement;
- Any information the Member needs in order to decide among all relevant treatment options;
- The risks, benefits, and consequences of treatment or non-treatment; and
- The Member's right to participate in decisions regarding his/her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

SECTION 5

REIMBURSEMENT PROVISIONS

5.1 **Payment.** Plan shall reimburse Facility for Covered Services rendered to Members at the rates set forth on **Attachment A**, less Member Expenses that will be collected from the Member. The obligation for payment under this Agreement for Covered Services rendered to a Member is solely that of Plan, except that Facility may also seek payment from a Member for Member Expenses or Non-Covered Expenses, to the extent permitted by Regulatory Requirements and if such Member Expenses are permitted by the Managed Medicaid Plan. Facility shall provide the name and address of the official payee to whom payment may be made and promptly submit all information needed for Plan to make payment to Facility.

5.1.1 If Plan provides for electronic remittances (ERA) and/or the electronic payment of Claims (EFT) to any other Facility provider, upon execution of this agreement Plan will promptly take steps to assure Facility can electronically receive remittances (ERA) and/or the electronic payment of claims (EFT) in accordance with policies and procedures established by Facility and Plan, and in accordance with the pricing of new codes and new services and procedures, as described in Section 5.2 below.

5.1.2 If Plan cannot administer and accurately pay the contracted rates, negotiations can be opened at any time to resolve rate structure adjudication issues.

5.1.3 Plan is liable and must pay Facility for any Covered Services provided to Members which are authorized by the Plan or its agent unless Facility knowingly provided false and misleading information upon which the authorization was granted.

5.1.4 Plan shall not retroactively deny a Claim for Emergency Services because the condition, which appeared to be an Emergency Medical Condition under the prudent layperson standard, was determined to be a non-emergency. The Plan shall not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms. The Plan shall not refuse to cover Emergency Services based on the emergency room provider, hospital, or fiscal agent not notifying the Member's PCP, Plan or applicable State entity of the Member's screening and treatment within ten (10) calendar days of presentation for Emergency Services. The Plan shall not deny payment for treatment when a representative of the entity instructs the Member to seek Emergency Services. The Plan shall not deny payment for treatment obtained when a Member had an Emergency Medical Condition and the absence of immediate medical attention would not have had the outcomes specified in 42 CFR 438.114(a) of the definition of emergency medical condition. The Plan shall be responsible for payment to providers in and out of the Service Area, without requiring prior approval, for Emergency Services and Post-Stabilization Services, including but not limited to the following services and in accordance with the SSA Section 1867 (42 U.S.C. 1395dd): 1) Determining if an emergency exists for Medicaid MCO Program Members when the medical screening service is performed; 2) Treatment as may be required to stabilize the medical condition, including emergency admissions; and 3) Transfer of the individual to another medical facility within SSA Section 1867 (42 U.S.C. 1395 dd) guidelines and other applicable State and federal regulations. Plan shall prior approve any services performed after the Facility, whether in or out of the Service Area, has stabilized the patient. Plan shall cover services subsequent to stabilization if: 1) said services were pre-approved by the Plan; 2) said services were not pre-approved by the Plan because the Plan did not respond to the Facility's request for pre-approval of said services within one (1) hour after the request was made; 3) Plan could not be contacted for pre-approval; or 4) Plan and the treating

physician cannot reach an agreement concerning the Member's care, and a network physician is not available for consultation. In this situation, the Plan shall give the treating physician the opportunity to consult with a network physician and the treatment physician may continue with the care of the Member until a network physician is reached or one of the criteria of 42 CFR 422.133(c)(3) is met.

5.1.5 The Plan's financial responsibility for Post-Stabilization Services it has not pre-approved ends when 1) a network physician with privileges at the treating hospital assumes responsibility for the Member's care; 2) a network physician assumes responsibility for the Member's care through transfer; 3) a representative of the Plan and the treating physician reach an agreement concerning the Member's care; or 4) the Member is discharged.

5.1.6 Plan agrees that it will not deny payment solely because Facility fails to verify eligibility or pre-authorization for services rendered to Members. This will not relieve Facility of its obligations in the normal course of business to make responsible attempts to obtain authorization for non-emergency services.

5.1.7 If Facility's Claim is partially or totally denied in a remittance advice or other appropriate written notice, then Facility may submit an appeal for reconsideration to Plan within twelve (12) months of the receipt of the partial or total denial of the Claim. The reconsideration request should include any documentation or information reasonably necessary to support the appeal for reconsideration. Plan must respond to the reconsideration request within sixty (60) days after receipt of the request.

5.1.8 Notwithstanding any provision in this Agreement to the contrary, Facility may appeal and Plan shall review Claims that were totally or partially denied for Facility's failure to i) file a Claim within the time limit set forth in this Agreement; ii) provide a notice required by this Agreement; iii) follow Plan Policies; iv) determine eligibility; or v) obtain an authorization required by this Agreement, to determine if the services rendered were Covered Services, were Medically Necessary and would have been authorized. If in its evaluation of Facility's reconsideration request, Plan reasonably determines that the services provided by Facility, including but not limited to outpatient diagnostic imaging services, were Covered Services, were Medically Necessary and appropriate for the Covered Person's condition, and would have been authorized by Plan, then Plan shall reverse its denial and reimburse Facility in accordance with **Attachment A** within twenty (20) days of such determination. If, in its evaluation of Facility's appeal, Plan reasonably determines that the services in question were Non-Covered Services, and/or were not Medically Necessary and appropriate for the Covered Person's condition, and would not have been authorized by Plan even had Facility not failed to comply with the administrative programs, policies, procedures, or Plan Policies, then Plan may uphold its denial, subject to Facility's right to pursue whatever additional remedies may be available to it.

5.1.9 Notwithstanding any provision herein to the contrary, Facility shall be reimbursed for any services provided pursuant to Member's successful appeal, grievance or request for continuation of services.

5.2 **Submission of Claims.** Facility shall submit initial Claims with applicable coding including, but not limited to, DRG, ICD9-CM, CPT, Revenue and HCPCS coding in accordance

with the following time periods: (a) when Plan is primary, within one hundred eighty (180) days following the date of discharge for inpatient services or the date of service for all other services; (b) when Plan is secondary, within one hundred eighty (180) days following the final determination of the primary insurer; or (c) when Facility is not aware that the patient is a Member, within one hundred eighty (180) days following the date Facility is provided with information identifying the patient as a Member. Facility shall not, under any circumstances, submit a Claim for payment more than three hundred sixty-five (365) days from the date of service. Plan will accept as accurate the final DRG billed by Facility if that DRG was accurately determined using the then current ICD-9-CM/DRG grouper as published by the Federal Register through Facility Health Information Management department.

5.2.1 If Plan provides for the electronic submission of claims by any other Participating Provider, upon execution of this agreement, Plan will promptly take steps to assure Facility can electronically submit Claims in accordance with policies and procedures established by Facility, Plan and their respective claims clearinghouses.

5.2.2 Plan agrees not to perform any acts of bundling or unbundling of services on claims submitted and their related coding that is inconsistent with Medicaid protocols, as such protocols may be amended from time to time pursuant to Section 5.11. Plan will follow the billing guidelines established by CMS for Inpatient and Outpatient and consistent with South Carolina Medicaid Payment Systems that define a covered charge.

5.2.3 Plan will allow for the interim billing of Claims and payment thereof every thirty (30) day period of continuous care, when Members receive services from Facility over more than a thirty (30) day period.

5.3 **Prompt Pay.** Plan shall pay any and all uncontested portions of Claims submitted within thirty five (35) days of Receipt or such shorter time frame as required by applicable Regulatory Requirements. Plan shall pay ninety percent (90%) of all Clean Claims from Facility, either in individual or group practice or who practice in shared health facilities, within thirty (30) days of the date of Receipt. Plan shall pay ninety-nine percent (99%) of all Clean Claims from Facility, either in individual or group practice or who practice in shared health facilities, within ninety (90) days of the date of Receipt. Plan and Facility may, by mutual agreement, establish an alternative payment schedule.

5.3.1 Plan agrees not to delay payment for coordination of benefits or third party liability unless coordination of benefits or third party liability has been determined to actually exist. Plan further agrees to accept and utilize in its coordination of benefits or third party liability determination any information (if applicable) obtained from Member on forms created by Facility and made available to Plan upon request.

5.3.2 If Plan contests Facility's Claim or any portion of a Claim, Plan shall notify Facility in writing within thirty (30) days after Receipt of the Claim by Plan that the Claim is contested. The notice that the Claim is contested must specifically identify the contested portion of the Claim and the specific reason for contesting the Claim, and must include a request identifying the specific additional information required. If Plan requests additional information, Facility must, within thirty-five days (35) after receipt of such request, mail or electronically

transfer the information to Plan. Plan shall pay the claim or portion of the claim within forty-five (45) days after receipt of the requested information.

5.3.3 Notwithstanding anything to the contrary or additional information requested and in all cases, Plan shall pay or deny any Claim submitted no later than one hundred twenty (120) days after receiving the Claim. Failure to do so shall create an uncontestable obligation to pay the Claim.

5.3.4 Payment of a Claim is considered made on the date the payment was received by or electronically transferred to Facility.

5.3.5 If Plan has entered into a capitated reimbursement arrangement with Facility, all encounter data submissions shall be subject to the same standards of completeness and accuracy as required for proper adjudication of fee-for-service claims.

5.3.6 The parties agree that all Medicaid benefit determinations are within the sole and exclusive authority of SCDHHS.

5.4 **Reimbursement for FQHC/RHC Covered Services.** If Facility is a FQHC/RHC, the following shall apply:

5.4.1 Plan shall adhere to federal requirements for reimbursement for FQHC/RHC Covered Services. This Agreement shall specify the agreed upon payment from Plan to the FQHC/RHC. Any bonus or incentive arrangements made to the FQHC/RHC associated with Members must also be specified to SCDHHS. The Plan shall submit the name of the FQHC/RHC and number of Medicaid encounters paid to each FQHC/RHC by month of services to the SCDHHS for State Plan required reconciliation purposes. This information shall be submitted in the format required by SCDHHS as contained in the MCO Policy and Procedure Guide.

5.4.2 Plan shall not make payment to a FQHC/RHC which is less than the level and amount of payment which Plan makes for similar Covered Services if the Covered Services were furnished by a provider which is not a FQHC/RHC.

5.4.3 Plan shall not make payment to a FQHC/RHC which is less than the level and amount of payment the FQHC/RHC would have been entitled to receive as reimbursement from the South Carolina Medicaid Program for a fee-for-service claim.

5.5 **Overpayment/Underpayment Process.** All Plan requests for refund of overpayments shall be submitted in writing. Facility detailed Claim level requests for amounts underpaid shall be submitted electronically or in writing. Plan will be obligated to respond to underpayment requests provided with Claim level detail that includes the specific reasons for non-payment in a format acceptable to Facility. The other party shall thereafter respond within thirty-five (35) days following receipt of such request.

5.5.1 Regardless of any provision to the contrary, no request shall be allowed for any alleged overpayment or underpayment made more than three hundred and sixty-five (365) days from inpatient discharge dates and outpatient service dates, as applicable. Neither party has a

right of offset, any right of retroactive reductions in payment, or any right to demand a refund of alleged overpayment or underpayment unless performed in accordance with this Section 5.5.1 and mutually agreed upon in writing by the parties.

5.5.2 Both Plan and Facility agree that neither will seek overpayment or underpayment recovery from the other for any individual Claim where the aggregate (not per unit) discrepancy is less than fifty dollars ($50) for inpatient or outpatient services. This waiver of overpayment or underpayment recovery does not apply to systemic issues that may be found by either party relative to contracted rates, which will be corrected in accordance with this Agreement. If after formal correspondence between the parties, resolution of systemic payment issues is not achieved; either party can give thirty (30) days notice to delete the waiver from this Agreement.

5.5.3 In the event that the State Agency notifies the Plan that it will seek overpayments from Facility, Plan shall notify the Facility within five (5) business days of receipt of such notice by the State Agency.

5.6 **Coordination of Benefits.** Subject to applicable state and federal laws and regulations regarding confidentiality of medical and personal information, Plan and Facility agree to reasonably cooperate to exchange information relating to coordination of benefits and third party liability with regard to Covered Services rendered to a Member, including without limitation, claims that may be covered by automobile insurance, workers' compensation coverage, other health insurance, or otherwise give rise to a claim for third party liability. The parties agree to inform each other in writing of the receipt of any payment for Covered Services received from sources other than Plan. The execution of this Agreement in no way waives Facilities right to bill and collect from Plan as a secondary or tertiary insurer to Member's primary insurer, including the billing and collection from Plan of Member co-payments, coinsurance, deductibles and/or other cost-share amounts.

5.7 **Member Protection Provision.** To the extent specifically prohibited by law and the Medicaid MCO Program:

5.7.1 Facility agrees that in no event, including, but not limited to, non-payment by Plan, insolvency of Plan, or breach by Plan of this Agreement, shall Facility bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Member for Covered Services provided pursuant to this Agreement, other than Member Expenses. Facility shall accept payment made by Plan as payment-in-full for Covered Services provided and shall not solicit or accept any surety or guarantee of payment from the Member, or the parents, guardian, spouse or other legally responsible person of the Member. Facility or its designated agent shall execute the Hold Harmless Agreement attached hereto as **Attachment D**.

5.7.2 The provisions of this Section 5.7 shall be construed in favor of the Member, shall survive the termination of this Agreement regardless of the reason for termination, including the insolvency of Plan, and shall supersede any oral or written contrary agreement between Facility and a Member or the representative of a Member.

5.7.3 The Plan shall not refuse to compensate the Facility for Covered Services or otherwise disadvantage the Facility because the Facility, its employees, medical staff, vendors, or anyone else contracted with or in anyway affiliated with the Facility, have in good faith communicated with or advocated on behalf of one or more of its prospective, current or former Members regarding the provisions, terms or requirements of the Plan's Managed Medicaid Plans as they relate to the needs of the Member; or communicated with one or more of its prospective, current or former Members with respect to the method by which the Facility is compensated by the Plan for Covered Services provided to the Member.

5.8 **Member Expenses.**

5.8.1 Plan agrees that Facility may pursue collection of Member Expenses at any time prior to, during or after services are rendered, if permitted by the Managed Medicaid Plan.

5.8.2 Subject to any Regulatory Requirements and Facility's policies, procedures and bylaws, Facility may waive all or any portion of Member Expenses that may be required under a Member's Managed Medicaid ~~Plans~~Plan without the prior written consent of Plan. Plan agrees to cooperate with all Facility policies and procedures for the collection of Member bad debt.

5.8.3 Subject to any Regulatory Requirements, Facility may pursue collection of Non-Covered Services.

5.9 **Claims Disputes.** The parties agree to attempt to resolve disputes involving Claims payment, denial, overpayment or underpayment issues directly. Should the parties fail to resolve such issues directly, ongoing disputes shall be resolved in accordance with Section 9, Dispute Resolution, below.

5.9.1 In the event Facility does not file a Claim for medical services rendered to a Member within the timeframes outlined above, or fails to follow Plan's practices, including prior authorization due to Member's failure to provide Facility with an accurate identification card in a timely manner, Plan will adjudicate and pay the Facility's Claim based on whether the services in question (a) were Covered Services; (b) were Medically Necessary and appropriate for the Member's condition; and (c) would have been authorized or paid by Plan had Facility received accurate and timely identification card information from the Member at the time of service or had complied with Plan practices.

5.10 **New Technology and Services**. To the extent that Facility expands or adds a new type of service or technology, or provides Covered Services to a Member that were not offered by Facility or not priced in **Attachment A** on the Effective Date of the initial or any renewal term, the parties will negotiate rates for such services for up to a sixty (60) day period following notice to Plan by Facility. Upon agreement on a reimbursement rate for such new service or technology, the parties shall amend **Attachment A** to include such service and the corresponding rate. Plan agrees to promptly load the reimbursement rate pursuant to Section 5.1. If the parties cannot reach an agreement on the application of existing rates or as to new rates for the services affected by the end of this sixty (60) day period, Facility will be considered a non-participating provider for that service until such time as the parties may mutually agree upon other rates for such services.

5.11 **New and Updated Coding.** In the event Medicare or the AMA reclassify, add, change or delete Diagnosis-Related Groups ("DRGs") and descriptions and/or Current Procedural Terminology ("CPT") codes and descriptions that affect a service definition for inpatient or outpatient services, and as such alterations may relate to Covered Services specified in the rate sheets incorporated into **Attachment A**, the parties will meet in good faith to negotiate rates for a thirty (30) day period following notice by one party to the other of such coding modification(s). The intent of both parties during the negotiation period will be to align the coding modifications with payment rates existing in the then current rate sheets or with new rates that reflect the service being delivered, such that the financial impact is neither to the detriment of nor benefit to either party. From the period beginning with the effective date of the modification by Medicare or AMA to the service definitions (effective as of October 1 for DRG code changes, as of January 1 for CPT codes changes, and as of the effective date of any other modifications by CMS to the outpatient coding), to the end of the thirty (30) day period, payment for the modified service definition shall fall to and be mapped to the most applicable rate on the then current rate sheets, notwithstanding that components may have been added or subtracted from such service definition. Plan acknowledges that Facility's Claim will reflect the new inpatient or outpatient payment methodology codes, and Plan will use an internal mapping process to make payment using the payment methodology in place prior to the effective date of the applicable coding modifications until Plan completes its implementation of modifications in coding. In the event the parties cannot reach an agreement on the application of existing rates or new rates for the services affected by the expiration of the thirty (30) day period, Facility shall be paid at **thirty** percent (30%) of Billed Charges for such Covered Services until such time as the parties may mutually agree upon rates for such services. For purposes of determining payment under this Agreement, the parties acknowledge and agree that the modifications in coding and the respective revised payment methodology referenced herein shall be calculated retroactive to the respective effective date of such modification in coding, and that payment for such affected Claims shall be reconciled accordingly.

5.12 **Disclosure of Payment by Plan to SCDHHS.** Facility shall fully disclose to regulatory authorities the method and amount of compensation or other consideration to be received from Plan upon request.

SECTION 6

LIABILITY OF PARTIES, LAWS, REGULATIONS AND LICENSES

6.1 **Legal Responsibility.** Facility and Plan agree that each is responsible for the legal consequences and costs of its own acts or omissions, or both, and is not responsible for the acts or omissions, or both, of the other party. However, nothing in this section shall be construed to subject Plan liability for clinical decisions made solely by Facility, and nothing in this section limits that ability of Plan to otherwise prudently administer its provider contracts.

6.2 At all times during the term of the Agreement, Facility shall indemnify and hold SCDHHS harmless from all claims, losses, or suits relating to activities undertaken pursuant to the Medicaid MCO Contract unless the Facility is a state agency. For all Facilities that are not state agencies, Plan shall indemnify, defend, protect, and hold harmless SCDHHS and any of its officers, agents, and employees from:

6.2.1 Any claims for damages or losses arising from services rendered by any subcontractor, person, or firm performing or supplying services, materials, or supplies for the Plan in connection with the performance of this Agreement;

6.2.2 Any claims for damages or losses to any person or firm injured or damaged by erroneous or negligent acts, including disregard of State or federal Medicaid regulations or legal statutes, by Plan, its officers, employees, or subcontractors in the performance of this Agreement;

6.2.3 Any claims for damages or losses resulting to any person or firm injured or damaged by Plan, its officers, employees, or subcontractors by the publication, translation, reproduction, delivery, performance, use, or disposition of any data processed under this Agreement in a manner not authorized by the Agreement or by federal or State regulations or statutes;

6.2.4 Any failure of the Plan, its officers, employees, or subcontractors to observe the federal or State laws, including, but not limited to, labor laws and minimum wage laws;

6.2.5 Any claims for damages, losses, or costs associated with legal expenses, including, but not limited to, those incurred by or on behalf of SCDHHS in connection with the defense of claims for such injuries, losses, claims, or damages specified above;

6.2.6 Any injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against SCDHHS or their agents, officers or employees, through the intentional conduct, negligence or omission of the Plan, its agents, officers, employees or subcontractors.

6.3 In the event that, due to circumstances not reasonably within the control of Plan or SCDHHS, (i.e., a major disaster, epidemic, complete or substantial destruction of facilities, war, riot or civil insurrection), neither the Plan, SCDHHS, subcontractor(s), or Facility will have any liability or obligation on account of reasonable delay in the provision or the arrangement of Covered Services; provided, however, that so long as the Plan's certificate of authority remains in full force and effect, the Plan shall be liable for the Covered Services required to be provided or arranged for in accordance with the terms of this Agreement.

6.4 **Facility Insurance.** Facility will maintain all such policies of liability and malpractice insurance, or self insurance for said coverage, as shall be necessary to adequately protect Plan's Members and to insure Facility against any claims for damages arising in connection with the performance of Facility's responsibilities under this Agreement. Facility shall provide such insurance coverage at all times during the term of the Agreement and, upon execution of the Agreement, shall furnish Plan with written verification of the existence of such coverage. This clause shall survive for a period of time following the termination of this Agreement not less than the applicable statute of limitations. Facility agrees to provide, and/or have its insurance carrier(s) provide written notice to Plan at least ten (10) days prior to any suspensions, cancellations and/or adverse modifications to the above noted professional liability insurance coverage.

6.5 **Plan Insurance.** Plan will maintain such policies of professional liability, general liability insurance, workers' compensation as required by law, and other insurance, or self insurance for said coverage, as shall be necessary to insure Plan against any claims for damages arising in connection with the performance of Plan's responsibilities under this Agreement. Upon request, Plan shall provide Facility with a current certificate of insurance as reasonable proof that Plan has obtained adequate insurance coverage. This clause shall survive for a period of time following the termination of this Agreement not less than the applicable statute of limitations. Plan agrees to provide, and/or have its insurance carrier(s) provide written notice to Facility at least ten (10) days prior to any suspensions, cancellations and/or modifications to the above noted insurance coverage.

6.6 **Laws, Regulations and Licenses.**

6.6.1 Facility shall be currently licensed and/or certified under applicable State and federal statutes and regulations and shall maintain throughout the term of this Agreement all necessary licenses, certificates, registrations and permits as are required to provide the health care services and other related activities delegated by Plan hereunder. During the term of this Agreement, Facility agrees to maintain Joint Commission on Accreditation of Healthcare Organization (JCAHO) accreditation for acute care hospitals. Facility will give immediate, written notification by certified mail of any administrative legal action or complaint filed and prompt notice of any claim made against Facility by a subcontractor or Member which may result in litigation related to the Medicaid MCO Contract. Further, Facility shall promptly notify Plan in writing of restriction, revocation or suspension to its license, certification or JCAHO accreditation, whether voluntary or involuntary, that materially restricts Facility's ability to meet its obligations under this Agreement. Facility shall recognize and abide by all Regulatory Requirements.

6.6.2 If Facility performs laboratory services, Facility shall meet all applicable State and federal requirements related to the provision of laboratory services, including but not limited to having a Clinical Laboratory Improvement Amendment (CLIA) Certificate of Waiver or Certificate of Registration with a CLIA identification number. Facility can only provide services that are consistent with its type of CLIA certification.

6.6.3 Plan shall maintain all licenses, certifications, permits, and financial solvency and reserve requirements, without material restriction, which are required to enter into a Medicaid MCO Contract and a Participating Facility agreement according to applicable state and federal law, including without limitation accreditation by an authorized accreditation organization or entity. During the term of this Agreement, Plan agrees to maintain National Committee for Quality Assurance (NCQA) accreditation for health plans. Plan will promptly notify Facility in writing of restriction, revocation or suspension to its license, certification or NCQA accreditation, whether voluntary or involuntary. Plan shall comply with all applicable state and federal rules and regulations.

6.6.4 Plan represents that it has and will maintain the minimum statutory reserve, deposit, surplus and other insolvency protections as required the Regulatory Requirements and will provide Facility with a copy of all financial filings required pursuant to the Regulatory Requirements. Should Plan fail to comply with the foregoing representation at any time, Plan

shall notify Facility of its failure to meet minimum statutory reserve requirements and provide a description of the plan to cure the statutory reserve deficiency.

SECTION 7

NOTICES AND DELIVERY OF NOTICES

7.1 **Delivery of Notices.** Unless otherwise specified in this Agreement, any notice or other communication required or permitted shall be in writing. All written notices or communication shall be deemed to have been given when delivered in person, or upon receipt when delivered by first-class United States mail, proper postage prepaid with signature required, or the next business day following the date notice is provided via overnight delivery. All notices shall be properly addressed to the appropriate party at the address set forth below or to another more recent address of which the sending party has received written notice. Notwithstanding the previous sentence, all notices of termination of this Agreement by either party must be sent by certified mail, return receipt requested. Each party shall provide the other with any changes to their respective addresses for notice below.

Plan:	Select Health of South Carolina, Inc. P.O. Box 40849 Charleston, SC 29423 Attn: Rob Aubrey, Chief Financial Officer
Facility:	South Atlantic Division 900 Island Park Dr, Suite 202A Daniel Island, SC 29492 Attn: Chief Financial Officer
With a Copy to:	East Florida Division 450 East Las Olas Blvd, Suite 1100 Ft. Lauderdale, FL 33301 Attn: Regional Vice President, Managed Government Programs Orange Park Shared Service Center 335 Crossing Blvd Orange Park, FL 32073 Attn: Vice President, Managed Care HCA Inc. Legal Department 1 Park Plaza, Bldg 1-4E Nashville, TN 37203 Attn: General Counsel

SECTION 8

RECORDS

8.1 **Confidentiality of Member Information and Records.** Plan and Facility shall ~~use commercially reasonable efforts to~~ preserve the confidentiality of Member information and records in accordance with applicable state and federal laws, statutes and regulations, including without limitation HIPAA.

8.1.1 To the extent required by applicable Regulatory Requirements, the parties shall ~~use commercially reasonable efforts to~~ obtain any Member consent required in order to provide the other with requested information and records or copies of records for the purpose of paying Claims. As part of its admission process, Facility routinely includes written requests for the patient's consent to provide documents and information to the patient's insurer for this purpose.

8.1.2 Facility shall safeguard Member information according to applicable Regulatory Requirements and Plan's written safeguards, which shall require that Facility (i) meet the requirements of 42 CFR Part 431, Subpart F (2005, as amended) and S.C. Code R. 126-170 et seq. (Supp. 2000, as amended); (ii) comply with any stricter State or federal confidentiality standards which apply to specific types of information or information obtained from outside sources; (iii) require the written consent of the Member or potential Member before disclosure of information about him or her; (iv) not prohibit the release of statistical or aggregate data which cannot be traced back to particular individuals; and (v) acknowledge that violators will be sanctioned.

8.1.3 Facility further acknowledges that all material and information, in particular information relating to Members or potential Members, which is provided to or obtained by or through the Plan's performance under the Medicaid MCO Contract, whether verbal, written, electronic file, or otherwise, shall be reported as confidential information to the extent confidential treatment is provided under State and federal laws.

8.1.4 All information as to personal facts and circumstances concerning Members or potential Members obtained by the Facility shall be treated as privileged communications, held confidential, and not divulged without the written consent of Plan or SCDHHS or the Member/potential Member, provided that nothing stated herein shall prohibit the disclosure of information in summary, statistical, or other form which does not identify particular individuals. The use or disclosure of information concerning Members/potential Members shall be limited to purposes directly connected with the administration of the Medicaid MCO Contract.

8.2 **Maintenance of Records.** As applicable, the parties respectively will maintain medical, eligibility, enrollment/disenrollment, financial and other administrative records related to Members and Covered Services rendered by Facility to Members under this Agreement in such form and such time periods as required by applicable State and federal laws, licensing, accreditation and reimbursement rules and regulations to which the parties are subject and in accordance with industry standards. Specifically, Facility shall maintain an adequate record system for recording services, service providers, charges, dates and all other commonly accepted 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). The medical records shall be legible, maintained in detail consistent with good medical practice and includes medical charts, prescription orders, diagnoses for which medications were administered or prescribed, orders for

laboratory, radiological EKG and other tests and the results of the tests and other documentation sufficient to disclose the quality, quantity, appropriateness and timeliness of the Covered Services. Members and their representatives shall be given access to any requested copies of the Members' medical records, to the extent and in the manner provided by S.C. Code Ann. §44-115-10 et. seq., (Supp. 2000), as amended and subject to reasonable charges.

8.3 **Retention of Records.**

8.3.1 Unless the longer period required pursuant to Section 8.3.2 applies, any and all member records, whether financial, medical or otherwise, shall be retained for a period of three (3) years after the last payment was made for services provided to a Member and retained further if the records are under review or audit until the review or audit is complete. This requirement pertains to the retention of records for Medicaid purposes only; other State or federal rules may require longer retention periods. For example, pursuant to S.C. Code Ann. § 44-115-120, physician Providers shall retain all Member medical records at the site where the medical services are provided, for at least ten (10) years for adult patients and at least thirteen (13) years for minors. These minimum record keeping periods begin to run from the last date of treatment.

8.3.2 Facility shall retain and safeguard all records originated or prepared in connection with Facility's performance of its obligations under the Medicaid MCO Contract, including but not limited to, working papers related to the preparation of fiscal reports, medical records, progress notes, charges, journals, ledgers, and electronic media, in accordance with the terms and conditions of the Medicaid MCO Contract. Facility further 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 Medicaid MCO Contract, and as further required by SCDHHS for a period of five (5) years from the expiration date of the Medicaid MCO Contract, including any Contract extensions. If any litigation, claim or other actions involving the records have been initiated prior to the expiration of the five (5) 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 five (5) year period, whichever is later. If Facility stores records on microfilm or microfiche, Facility must produce, at its expense, legible hard copy records upon request of State or federal authorities, within fifteen (15) calendar days of the request.

8.4 **Government Agency Access.** ~~Subject to~~In accordance with Facility's policies, procedures and bylaws, Facility shall permit SCDHHS, U.S. Department of Health and Human Services (HHS), CMS, Office of Inspector General Comptroller, State Auditor's Office, and the South Carolina Attorney General's Office to evaluate through audit, inspection, or other means, whether announced or unannounced, any records pertinent to this Agreement, including the quality, appropriateness and timeliness of Covered Services and the timeliness and accuracy of encounter data and practitioner claims submitted to Plan. Plan shall cooperate with any such evaluation, and when performed. Upon request of the above federal and State entities, Plan shall assist in such reviews.

8.5 **Audits.** Plan and Facility shall have the right to conduct audits of the other, no more than one (1) time per calendar year, provided that such audits shall be conducted pursuant to procedures in this Agreement. Regardless of anything to the contrary, Plan audit requests shall be submitted in writing, which requests shall include the proposed commencement date and the

type and scope of the audit. Following receipt of any such Plan audit requests, Facility will communicate with Plan to discuss alternative date(s), the scope of any such audit request, as well as any issues or concerns regarding the requested audit. The parties must mutually agree on the date, type and scope of any audits conducted prior to commencement of any audit. Plan, and any authorized designee, shall abide by the customary audit policies and procedures established by the Facility and/or its associated patient account services vendor pertaining to the audit of Claims.

8.6 **Copy Costs.** Plan shall pay Facility $1.00 per page or such amount(s) provided for under applicable law, whichever is lesser, for copies of any and all records requested under this Agreement, excluding copies of medical records requested in conjunction with initial claims processing for determination of payment or denial of such claims.

8.7 **Termination of Medicaid MCO Contract.** The parties recognize that in the event of termination of the Medicaid MCO Contract for any of the reasons described in the Medicaid MCO Contract, Plan shall immediately make available to SCDHHS, or its designated representative, in a usable form, any and all records, whether medical or financial, related to the parties' activities undertaken pursuant to this Agreement. The provision of such records shall be at no expense to SCDHHS.

SECTION 9

DISPUTE RESOLUTION

9.1 **Disputes.** Plan and Facility agree that the parties are responsible for resolving any disputes arising with respect to the performance or interpretation of the Agreement, including without limitation disputes regarding Claims payment or denial, in accordance with the provisions of this Agreement. No dispute shall disrupt or interfere with the provisions of services to Members, and the parties shall attempt to resolve promptly any dispute by negotiation between designated representatives of the parties who have authority to settle the dispute. If the matter has not been resolved within sixty (60) days following the date of a party's written request for this negotiation, either party may initiate binding arbitration by providing written notice to the other party.

9.2 **Binding Arbitration.** In the event of a dispute between Plan and Facility which is not resolved as set forth above or which the parties cannot settle by mutual agreement, including without limitation, a dispute involving the interpretation of any provision of this Agreement, the parties' respective obligations under this Agreement, or otherwise arising out of the parties' business relationship (excluding any disputes that are currently the subject of individual or class litigation), such dispute shall be resolved by binding arbitration.

9.2.1 Arbitrations will be conducted by a single arbitrator selected by the parties from a panel of arbitrators created by the American Arbitration Association (AAA). In the event the parties cannot agree on the arbitrator, then the arbitrator shall be appointed by the AAA.

9.2.2 The arbitrator may construe or interpret but shall not vary or ignore the terms of this Agreement, shall have no authority to award extra contractual damages of any kind, including punitive or exemplary damages, and shall be bound by controlling law.

9.2.3 Unless otherwise agreed, any arbitration proceeding under this Agreement shall be conducted in the State in which the affected Facility is located, or, in the event more than one facility is involved, in any county in which a Facility is located in accordance with and subject to the Commercial Arbitration Rules of the American Arbitration Association then in effect, or under such other mutually agreed upon guidelines. Judgment upon the award rendered in any such arbitration may be entered in any court of competent jurisdiction sitting in county and state in which the affected facility is located or application may be made to such court for judicial acceptance and enforcement of the award, as applicable law may require or allow.

9.2.4 Disputes between the parties that involve claims processing and/or payment discrepancies, and/or common issues of fact or law, and/or that affect one or more Facilities, may be brought together in a single arbitration proceeding. Facility, either alone or in conjunction with its Affiliates, may join claims or issues to a pending informal dispute and/or arbitration without exhausting Plan's internal administrative procedures for addressing such claims/issues, if the claims/issues primarily involve related Claims processing and/or payment discrepancies and/or common issues of fact or law as other claims/issues that are part of the existing informal dispute resolution or arbitration.

9.2.5 The submission of any dispute to arbitration shall not adversely affect any party's right to seek preliminary injunctive relief with respect to an actual or threatened termination, repudiation or rescission of the Agreement.

9.2.6 The cost of any arbitration proceeding(s) hereunder shall be borne equally by the parties. Each party shall be responsible for its own attorneys' fees and such other costs and expenses incurred related to the proceedings.

SECTION 10

TERM AND TERMINATION

10.1 **Term.** The initial term of this Agreement shall be for one (1) year beginning October 1, 2009 and expiring September 30, 2010. Unless either party notifies the other no less than ninety (90) days prior to the expiration of the current term of the Agreement that it does not intend to renew the term of the Agreement, this Agreement shall automatically renew for subsequent one (1) year terms.

10.2 **Termination.** This Agreement may be terminated as follows:

(a) By mutual agreement of Plan and Facility;

(b) By either party, in the event of a material breach of this Agreement by the other party, upon thirty (30) days prior written notice to the other party. The breaching party has the right to cure the breach within thirty (30) days;

(c) By either party immediately upon written notice due to the other party's loss or suspension of licensure, loss of accreditation or certification, loss of insurance or failure to maintain financial reserves sufficient to provide the level of self-insurance required under this Agreement;

(d) By either party in the event of sale of substantially all of the operating assets of the other party where such selling party has failed to give and obtain the consent of assignment of this Agreement from the other party, as described in Section 11.2;

(e) By either party immediately and automatically upon verification that either party is terminated, barred, suspended or otherwise excluded from participation in, or has voluntarily withdrawn as the result of a settlement agreement related to, any program under Titles XVIII, XIX or XX of the Social Security Act;

(f) By either party upon thirty (30) days prior written notice in the event a party seeking to assign (as that term is defined in Section 11.2) this Agreement fails to obtain the other's written consent;

(g) By Facility immediately upon Plan's failure to meet the minimum statutory reserve, surplus, deposit or other solvency requirements pursuant to the Regulatory Requirements; or

(h) By Facility immediately if Plan becomes insolvent, or if a receiver is appointed for Plan or its property. In the case of termination under this subsection, the effective date of such termination shall be the date set forth in the written notice notifying Plan of the termination.

10.3 **Terminations and Extensions in Writing.** Any termination or extension of the Agreement shall only be valid when reduced to writing, duly signed by the parties, and attached to the original of this Agreement.

10.4 **Obligations of Parties After Termination.** If this Agreement expires or is terminated and a Member remains hospitalized on and after the effective date of such expiration or termination, Facility shall continue the provision of Covered Services to that Member for the period of time required by law, and Plan shall reimburse Facility for such Covered Services in accordance with the reimbursement rates set out in **Attachment A**.

SECTION 11

MISCELLANEOUS

11.1 **Amendment.** This Agreement and its attachments may be amended or modified only by the mutual written agreement of the parties. The parties agree to incorporate by reference into the Agreement all Regulatory Requirements, and any revisions of such Regulatory Requirements as they become effective. In the event that changes in the Agreement as a result of revisions and applicable federal or State law materially affect the position of either party, the parties agree to negotiate such further amendments as may be necessary to correct any inequities.

11.2 **Assignment/Change of Control.**

11.2.1 The parties agree to provide the other with written notice of any change in the party's name, ownership, Medicare or Medicaid certification number, or Federal Tax I.D. number, as applicable.

11.2.2 The parties acknowledge and agree that no provision contained herein restricts Facility from contracting with another MCO or other managed care entity. However, with respect to Covered Services provided under this Agreement, Facility shall not enter into any subcontracts or otherwise delegate Covered Services without Plan's prior written approval. Notwithstanding anything to the contrary, neither party may assign any of its rights and responsibilities under this Agreement to any person or entity without the prior written consent of the other party.

11.2.3 Nothing in this Agreement will permit Plan to assign or otherwise extend access to this Agreement or the rates set forth herein to any Affiliate of Plan (or its respective plan products), including without limitation, those entities that become Affiliates on or following the Effective Date.

11.2.4 As used in this Section 11.2, the term "assign" or "assignment" shall also include a change of control of a party by merger, consolidation, transfer, or the sale of thirty-three percent (33%) or more stock or other ownership interest in such party.

11.2.5 Any attempt by a party to assign its interest under this Agreement without complying with the terms of this paragraph shall be void and of no effect.

11.3 **Independent Contractor.** The relationship between Plan and Facility is solely that of independent contractors and nothing in this Agreement or otherwise shall be construed or deemed to create any other relationship, including one of employment, agency or joint venture.

Plan will notify Facility within thirty (30) days of any signed subcontractor or independent contractor agreement with any third party to provide services of any type that are covered under this Agreement. In the event that any portion of the services that Plan is responsible for hereunder are performed for or on behalf of Plan by a subcontractor or is delegated by Plan to a third party including but not limited to utilization management and radiology management, Plan shall be responsible for ensuring that such subcontractor or independent contractor furnishes such services in compliance with all of Plan's obligations under

this Agreement and the Regulatory Requirements. Notwithstanding any term to the contrary herein, Plan shall not delegate or subcontract the payment of Claims.

11.4 **Accounts Receivable Management Meetings.** On occasion and no more than bi-monthly, Facility may provide Plan with detailed accounts receivable aging by patient on Claims that are greater than sixty (60) days post discharge. Plan will respond with Claim level detail that includes the specific reasons for non-payment in a format acceptable to Facility within thirty (30) days of request. The parties will work diligently to resolve such outstanding accounts receivable.

11.5 **Name, Symbol and Service Mark.** During the term of this Agreement: (a) Plan may use Facility's name solely to make public reference to Facility as a Participating Provider or to include Facility's name in Participating Provider directories created and distributed by Plan; and (b) Facility may use Plan's name solely to make public reference to Plan as an organization, insurer, HMO or other type of MCO payor with whom Facility participates. Facility and Plan shall not otherwise use each other's name, symbol or service mark without prior written approval. During the term of this Agreement, Facility will be referenced as a Participating Provider in all Plan literature, electronic media, and provider directories for Managed Medicaid Plans covered under this Agreement.

11.6 **Confidentiality of Information.** Neither party shall disclose to third parties any confidential or proprietary business information which it receives from the other party, including, but not limited to, financial statements, business plans, protocols and programs; except that: (1) Facility may disclose information to a Member relating to the Member's treatment plan and the payment methodology; and (2) Plan may file the form of this Agreement with any federal or state regulatory entity as may be required by applicable law. Nothing in this provision shall be deemed to prohibit the parties from releasing confidential or proprietary information received from the other party if it is required in response to a valid subpoena or court order, or if it is necessary to provide the information to employees, officers or agents who have a need to know such information, and the parties shall ensure and warrant that such individuals have been informed of and agree to comply with the obligations in this provision. Notwithstanding anything to the contrary above, certain information regarding claims, eligibility, pre-authorization, coverage and reimbursement may be disclosed to Members or their representatives requesting such information.

11.7 **Entire Agreement.** This Agreement and any exhibits, attachments, addenda and amendments hereto constitutes the entire agreement between the parties in regard to its subject matter and supersedes any prior understandings and/or agreements between the parties, whether written or oral, with respect to the subject matter hereof.

11.8 **Facility Event.** In the event the Disclosed Agent by virtue of a sale, divestiture, closure, loss of lease or management contract, change to minority interest in joint-venture, etc. (a "Facility Event") no longer has the authority to contract on behalf of a Facility, then this Agreement shall become of no force or effect relative to such Facility as of the effective date of such Facility Event, except for those obligations incurred prior to the Facility Event, unless otherwise mutually agreed in writing by the Parties in order to accommodate a smooth transition through a divestiture. Notwithstanding the Facility Event, this Agreement shall remain in full

force and effect for all other Facilities listed on **Attachment C**. Facility will use commercially reasonable efforts to notify Plan not less than thirty (30) days prior to the occurrence of any Facility Event.

11.9 **Relationship.** References to the rights, responsibilities and obligations of Facility in the Agreement mean individually each of the facilities identified in **Attachment C**. Notwithstanding anything herein to the contrary, all such rights, responsibilities and obligations are individual and specific to such facilities and the reference to Facility herein in no way imposes any cross-guarantees or joint responsibility by, between or among such individual Facilities. Notwithstanding anything herein to the contrary, a breach or default by an individual Facility shall not constitute a breach or default by any other Facility. The Parties further agree that the responsibilities and obligations of Facility hereunder shall be the sole responsibility of such individual Facility and not that of the Disclosed Agent or any other individual Facility, or other Affiliate of Facility.

11.10 **No Incentives for Withholding of Care.** The parties acknowledge and agree that no provisions contained in the Agreement or any attachment provides incentives, monetary or otherwise, for the withholding of Medically Necessary care.

11.11 **No Waiver of Rights.** The waiver by either party of any breach of the other party of any provision of this Agreement shall not constitute a waiver of any subsequent breach of the same or different provision of this Agreement. Any waiver of any of the provisions of this Agreement shall be reduced to a writing and signed by both parties.

11.12 **No Third Party Beneficiaries.** Unless mandated by state or federal rules and regulations, there are no third party beneficiaries to this Agreement.

11.13 **Governing Law.** This Agreement shall be governed by and construed in accordance with the laws of the state in which the Facility is located (except to the extent pre-empted by federal law) without giving effect to its conflicts of laws principles.

11.14 **Severability**. If any part of this Agreement should be determined invalid, illegal, inoperative or contrary to law, such part shall be reformed, if possible, to conform to law; and in any event the remaining parts of this Agreement shall be fully effective and operative insofar as reasonably possible.

11.15 **Duplicate Originals**. This Agreement may be executed in one or more counterparts, each of which shall be deemed an original, but all of which constitute one and the same Agreement.

11.16 **Document Construction.** The parties agree that they have participated jointly in the negotiation and drafting of this Agreement (including the rates schedules set forth in **Attachment A** and the Managed Medicaid Plans designated in **Attachment B**, and have had access to legal counsel at all stages. In the event an ambiguity or question of intent or interpretation arises, this Agreement shall be construed as if drafted jointly by the parties, and no presumption or burden of proof shall arise favoring or disfavoring any party by virtue of the authorship of any provision(s) of this Agreement.

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

SELECT HEALTH OF SOUTH CAROLINA, INC.	**SOUTH ATLANTIC DIVISION, INC. as Disclosed Agent for those Facilities listed on Attachment C**
[INSERT: ADDRESS]	
Signature:	Signature:
Name:	Name:
Title:	Title:
Date:	Date:

Attachment A
Reimbursement

Plan agrees to reimburse Facility the reimbursement rates set out in the attached rate sheets, which are incorporated herein by reference, less any Member Expenses.

Attachment B

Managed Medicaid Plans & Corresponding Member Identification Cards

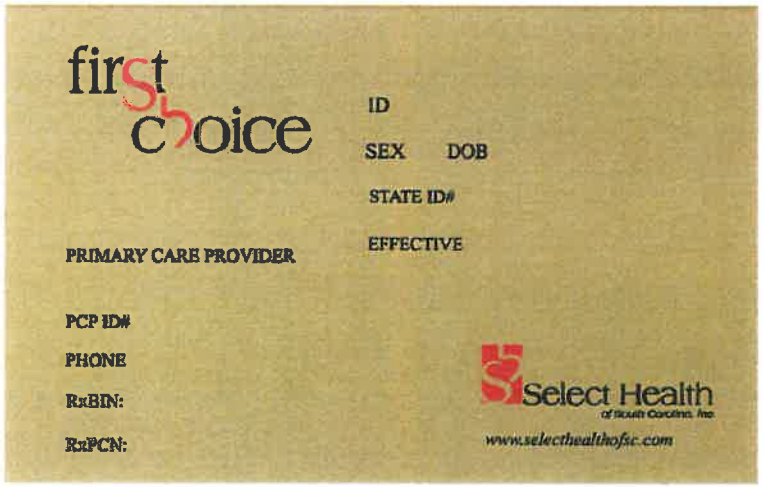
Subject to the provisions of this Agreement, Facility agrees to participate in the following Managed Medicaid Plans, as checked and initialed by both Parties:

First Choice by Select Health of South Carolina, Inc
First Choice Kids

The Plan shall forward to Facility proposed additions or deletions to the above list of Managed Medicaid Plans, together with the evidence of coverage, at least ninety (90) days prior to implementation of the new plan. If Facility agrees to the addition of the new plan in writing before its commencement, the Facility will be a Participating Provider in that Managed Medicaid Plan until the termination of the then current Term. The new plan's information shall be attached hereto as **Attachment B-1**, which shall be incorporated by reference herein.

Copies of sample Member identification cards for the above listed Managed Medicaid Plans are attached hereto and incorporated herein by reference. In the event Plan changes, replaces or modifies the Member identification cards used for the above listed Managed Medicaid Plans, Plan agrees to promptly provide Facility with a sample copy.

Front of card:



Back of card:

Members: 764-1877 in Charleston area or 1-888-276-2020 statewide. Call the Nurse Help line anytime day or night with your health questions - 1-800-304-5436.
Always carry your ID card and your Medicaid card. Always make sure your doctor is a First Choice provider. Go to an emergency room near you when you believe your medical condition may be an emergency. For all other non-emergency situations, call your primary care provider or our Member Services department

Providers: 764-1988 in Charleston area or 1-888-559-1010 statewide.
This card does not guarantee coverage or payment. Verify plan eligibility by calling First Choice, hecking the web site listed on the front of this card, or using the Medicaid eligibility system. Except for emergency care, some medical services require prior authorization. For admissions following emergency treatment, secure prior authorization within one business day following admission. Mail claims to: **P.O. Box 7120, London, KY 40742.**

Family planning services are not covered by First Choice, but are covered by Medicaid. Certain behavioral health and substance abuse initial assessment services are covered by First Choice and do not require prior authorization. Submit claims to Medicaid for all family planning and other mental health, alcohol and other drug (MH/AOD) abuse treatment services.

Pharmacy Prior Auth #: 1-866-610-2773
Pharmacy Claims Issues: 1-800-522-7487

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Attachment C

Facility Locations

Attachment

Member Hold Harmless

STATE OF SOUTH CAROLINA
DEPARTMENT OF INSURANCE

HOLD HARMLESS AGREEMENT

In accordance with the requirements of Act No. 83 of 1987, and as a condition of participation as a health care provider in Select Health of South Carolina, Inc., the undersigned Provider (hereinafter ""Provider"") hereby agrees not to bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have recourse against, enrollees of Select Health of South Carolina, Inc., or persons acting on their behalf, for health care services which are rendered to such enrollees by Provider, and which are covered benefits under enrollees' evidence of coverage. This agreement extends to all covered health care services furnished to the enrollee during the time he is enrolled in, or otherwise entitled to benefits promised by, Select Health of South Carolina, Inc. This agreement further applies in all circumstances including, but not limited to, non-payment by Select Health of South Carolina, Inc. and insolvency of Select Health of South Carolina, Inc. This agreement shall not prohibit collection of copayments from enrollees by Provider in accordance with the terms of the evidence of coverage issued by Select Health of South Carolina, Inc. The Provider further agrees that this agreement shall be construed to be for the benefit of enrollees of Select Health of South Carolina, Inc., and that this agreement supersedes any oral or written contrary agreement now existing or hereafter entered into between the Provider and such enrollees, or persons acting on their behalf.

Provider's Name: _____

Signature: _____

Type Name: _____

Title (if applicable): _____

Date: _____

Form SCID 505

Document comparison done by DeltaView on Wednesday, October 28, 2009 6:18:43 PM

Input:	
Document 1	pcdocs://charleston/627140/4
Document 2	pcdocs://charleston/627140/7
Rendering set	Standard

Legend:	
Insertion	
~~Deletion~~	
~~Moved from~~	
Moved to	
Style change	
Format change	
~~Moved deletion~~	
Inserted cell	
Deleted cell	
Moved cell	
Split/Merged cell	
Padding cell	

Statistics:	
	Count
Insertions	39
Deletions	48
Moved from	2
Moved to	2
Style change	0
Format changed	0
Total changes	91

South Atlantic Division, Inc.-HCA Hospitals

1. Header information refer to the facilities listed in Attachment C, there are no facilities listed in Attachment C, please list all facilities.

2. Section 2.4 Claim; list both UB-92 and CMS 1450, please list current version of each.

3. Section 2.6 Covered Services; refers to Attachment A, in reviewing attachment A there is no list of covered services it is the reimbursement page, please complete the reimbursement page and correct this section.

4. Section 2.7 Emergency Medical Condition: Delete and replace with the definition that in the contract between Select and SCDHHS.

5. Section 2.8 Emergency Services: delete the following phrase" as determined by the emergency physician or provider actually treating the Member"; it is not part of the contract terms in the contract between Select and SCDHHS.

6. Section 2.14 Medicaid MCO Program; delete the phrase "and/or HIO"

7. Section 2.15 Medically Necessary: delete the following phrase "member as directed by the treating physician"; it is not part of the definition in the contract between SCDHHS and Select.

8. Section 2.17 Member Expense: delete the following phrase" including without limitation co-payments, coinsurance, deductibles, other cost-share amounts, and amounts for Non-Covered Services. The only member expense is co-pays and that is for adults only. Non-covered services must be address separately.

9. Section 2.18 Non-Covered Services: delete this section and use the definition in the contract between SCDHHS and Select.

10. Section 2.18 State Medicaid Agency Materials: P&P guide will changed effective October 1, 2009, please delete "July 1, 2009" current contract was effective April 1, 2008, this will be amended October 1, 2009

11. Section 4.3 Member Loss of Eligibility: delete the following phrase" Facility may collect from the Member any amounts for services rendered subsequent to the loss of coverage under the applicable Managed Medicaid Plan".

12. Section 4.4.10 delete the following sentences" For Members, SCDHHS will enroll newborns into the same managed care plan as the Member mother for the first ninety (90) calendar days from birth unless otherwise specified by the Member mother. The newborn will be enrolled in the same managed care plan as the Member mother through the end of the month in which the ninetieth (90^{th}) day falls. The newborn's effective date will be the first day of the month of birth. The newborn shall continue to be enrolled with the Member mother's Plan unless the mother/guardian changes the enrollment". Delete the following phrase "including indicating whether the mother is a Medicaid MCO Program Member".

13. Section 4.4.13 deletes the word "reasonable" and the phrase "not be an undue burden for Facility".

14. Section 4.7.1 current version will be posted on SCDHHS website, please update contract to reflect that requirement.

15. Section 4.7.2. delete all the words "reasonable" and the last phrase "which are not unduly burdensome to Facility".

16. Section 4.7.3 deletes the last phrase" Notwithstanding anything to the contrary, Plan Policies are guidelines, and as such shall not be incorporated as a term of this Agreement".

17. Section 4.8 delete "agrees to reasonably" add the word "shall"

18. Section 5.1 delete the following phrase" except that Facility may also seek payment from a Member for Member Expenses".

19. Section 5.8.1 delete entire section

20. Section 5.8.2 delete entire section.

21. Section 8.1 delete the phrase "shall use commercially reasonable efforts to" and insert "shall"

22. Section 8.1.1 deleted the phrase "use commercially reasonable efforts to"

23. Section 8.4 delete the following phrase" Subject to Facility's policies, procedures and bylaws"

In reading the contract I didn't read in the contract where it states that a member includes the patient, parents, guardian, spouse or any other legally responsible person of the member being served.

Also I did not read in the contract the specifying that the facility shall not assign any of its duties and/or responsibilities under this contract without the prior written consent of the Plan.