
**UNIVERSITY PHYSICIANS HEALTHCARE dba UNIVERSITY PHYSICIANS HEALTH PLANS
PHYSICIANS SERVICES AGREEMENT**

Gila County Health Department

Effective: 10/6/09

UNIVERSITY PHYSICIANS HEALTHCARE dba UNIVERSITY PHYSICIANS HEALTH PLANS

PHYSICIAN SERVICES AGREEMENT

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UNIVERSITY PHYSICIANS HEALTHCARE dba UNIVERSITY PHYSICIANS HEALTH PLANS

PHYSICIAN SERVICES AGREEMENT

This Physician Services Agreement (the "Agreement") is entered into effective _____, between University Physicians, Inc. dba University Physicians Health Plans (an Arizona non-profit corporation) including University Family Care, KidsCare, University Physicians Care Advantage ("Plan") and Gila County Health Department ("Provider").

RECITALS

- A.** Plan has entered into contracts with the Arizona Health Care Cost Containment System ("AHCCCS") to offer various products such as KidsCare and other like products of the AHCCCS program.
- B.** Plan has entered into a contract with a Medicare Advantage Organization to provide services to Medicare beneficiaries who are Members of a Medicare Advantage Special Needs Plan.
- C.** Plan will provide services under the products of University Family Care, KidsCare, University Physicians Care Advantage and any other like products offered by University Physicians Health Plans, AHCCCS and Medicare Advantage Organization.
- D.** Provider and all affiliated with Provider identified in Exhibit 1 provide certain ancillary medical services in Arizona for all products of the Plan.
- E.** Plan wishes to contract with Provider as a subcontractor to provide certain covered medical and related services to eligible Plan members for all products.

AGREEMENTS

The parties hereby agree as follow:

SECTION 1. DEFINITIONS

The following terms shall have the meanings set forth below unless the context otherwise requires. All non-defined terms shall have the meanings established by AHCCCS rules and regulations.

- 1.1 Adverse Action/Decision** means any action for which a party may file a grievance or request for hearing, such as a claim or prior authorization denial.
- 1.2 AHCCCS** means the Arizona Health Care Cost Containment System, as authorized by A.R.S. § 36-2901 et seq., which is composed of the Administration, contractors, and other arrangement through which health care services are provided to a member.
- 1.3 Administration** means the Arizona Health Care Cost Containment System Administration.
- 1.4 Advance Directive** means written documents or instructions, such as living wills or health care proxies, made in advance of an incapacitating illness that states Member's treatment decisions, or identifies the person to make such treatment decisions if Member is unable to make it.
- 1.5 Alternative Resolution** means a process by which a grievance can be satisfactorily resolved within ten (10) days by means other than the formal procedures.
- 1.6 Capitation Payment** means a predetermined periodic payment made to Provider by Plan for providing Covered Services based on the number of assigned Members.
- 1.7 Clean Claim** means a claim that can be processed without obtaining additional information from the provider of the service or from a third party. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.
- 1.8 Complainant** means a provider or member exercising their rights to file a grievance or Request for Hearing regarding a denial or adverse action/decision issued by the Plan.
- 1.9 Copayment** means an amount specified by the Director that a Member pays directly to a contractor or provider at the time Covered Services are rendered.

1.10 Covered Services means the specific medical and surgical services in Providers area of specialty as designated in Exhibit 1 provided by Provider under AHCCCS rules and regulations and this Agreement, and for which the Provider assumes responsibility and agrees to provide to or obtain for Members.

1.11 EPSDT means Early and Periodic Screening, Diagnosis, and Treatment services for persons under twenty-one (21) years of age. EPSDT services are synonymous with "well-check" services provided to patients with commercial types of insurance.

1.12 Emergency Medical Services means services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could be expected to result in placing the patient's health in serious jeopardy, serious impairment of bodily functions, or serious dysfunction of any bodily organ or part.

1.13 Encounter means a record of medical services, submitted by a contractor and processed by AHCCCS that is rendered by a provider registered with AHCCCS to a member who is enrolled with the contractor on the date of service for which the contractor incurs any financial liability.

1.14 Fee-For-Service Payment means a method of retrospective payment to subcontractors by Plan for certain Covered Services based on a fee-for-service schedule.

1.15 Grievance means a complaint that initiates an administrative review that does not involve a hearing. A party may request a hearing after an administrative review.

1.16 Inpatient Services means Covered Services provided to Members admitted to a Participating Hospital.

1.17 KidsCare a program implemented by AHCCCS a Title XXI Children's Health Insurance Program to provide health care coverage statewide to eligible children under age 19 provided through existing AHCCCS health plans.

1.18 Medical Director means a physician licensed in Arizona appointed by Plan to manage the administration of Covered Services, Utilization Management and Quality Management and other matters relating to the provision of services to Members.

1.19 Medically Necessary means a Covered Service provided by the physician or other licensed medical practitioner of the healing arts and within the scope of practice under state law to prevent disease, disability, and other adverse health conditions or their progression or prolong life.

1.20 Members means AHCCCS eligible persons enrolled with Plan, and assigned to receive Covered Services from Providers pursuant to this Agreement.

1.21 Outpatient Hospital Services means a service provided in an outpatient hospital setting that does not result in an admission.

1.22 Participating Health Professional (PHP) means those physicians, doctors, Physician assistants, nurse practitioners, and other professionals: (a) who is employed by, contracted with, associated with or otherwise represented by Provider and is identified in Exhibit 1 to this Agreement (b) who is authorized by Provider to provide Medically Necessary Covered Services pursuant to this Agreement (c) who has been offered and completed all Plan application and credentialing requirements and has been approved by the Plan for participation under this agreement; and (d) who agrees to comply with all requirements and provisions of this Agreement.

1.23 Participating Provider means any person/organization who contracts with Plan for the provision of hospitalization and medical care to members (i.e., specialty care providers, hospitals, outpatient facilities, DME, etc).

1.24 Physician means any person M.D. or D.O. licensed in the state of Arizona

1.25 Primary Care Physician (PCP) means a physician who is a family practitioner, general practitioner, pediatrician, general internist or obstetrician or gynecologist with an assigned panel of members.

1.26 Prior Authorization means the process by which the Administration or contractor, whichever is applicable, authorizes, in advance, the delivery of covered services contingent on their medical necessity.

1.27 Provider means the person/organization contracting with the Plan to provide healthcare services to Plan members in accordance with this Agreement. Provider includes all PHP's.

1.28 Provider Reference Manual means the manual that contains the policies and procedures, and operating guidelines instituted by Plan for the use in providing services to Plan Members.

1.29 Quality Management means a methodology and activity used by professional health personnel through a formal program involving multiple organization components and committees to assess the degree of conformance to desired medical standards and practices and improve or maintain quality service and care

1.30 Referral mean the process by which a member is directed by a primary care provider or an attending physician to another appropriate provider or resource for diagnosis or treatment.

1.31 Replacement PHP a credentialed PHP, not necessarily contracted with the Plan, but who is approved to cover members in the absence of the member's Provider.

1.32 Request for Hearing means the review process through State AHCCCS Administration that occurs upon written request by a complainant dissatisfied with the Plan's decision/resolution to a filed grievance.

1.33 Respondent means a party responsible for the adverse action that is the subject of a grievance or request for hearing.

1.34 Specialty Care Obstetrician ("SCO") means a physician, SCP, nurse practitioner, or certified nurse midwife practicing in the field of obstetrics/gynecology who assumes primary responsibility for supervising, coordinating and providing Medically Necessary Covered Services relating to initial, antepartum, delivery and postpartum care to Members and for maintaining continuity of care with Member's PCP.

1.35 Specialty Care Physician ("SCP") means a qualified physician who practices a specific medical or surgical specialty and who contracts with Plan to accept referrals from PCPs for the purpose of providing Medically Necessary Covered Services in that specialty to Members.

1.36 Utilization Management means a methodology used by professional health personnel that assesses the medical indications, appropriateness, and efficiency of care provided.

SECTION 2. RIGHTS, RESPONSIBILITIES AND OBLIGATIONS OF PROVIDER AND PARTICIPATING HEALTH PROFESSIONALS

2.1 Services and Standards.

2.1.1 Only those PCP's and PHP's listed in Exhibit 1 will be allowed to render services under this agreement. If Provider wishes to add any PHP to Exhibit 1 of this agreement, such must be done as amendments to this contract with a 90 day advance notice to enable the added PHP to be properly credentialed. Provider shall ensure that all PHP's listed in Exhibit 1 comply with the terms, conditions and requirements of this Agreement.

2.1.2 Provider and its PHP's, if any, (hereafter collectively "Provider" except where noted) agree to provide, arrange for and coordinate all Medically Necessary Covered Services for Members in accordance with the provisions of this Agreement, including Emergency Medical Services twenty-four (24) hours a day, seven (7) days a week, including holidays. In the event Provider arranges for back up or temporary replacement coverage by another provider ("Replacement PHP"), Provider shall notify Plan for such Replacement PHP in accordance with 2.1.1 above.

2.1.3 Provider shall provide Medically Necessary Covered Services to Members through office visits during regular office hours, after hour office visits, skilled nursing facility visits, home visits or other appropriate non-office visits such as emergency and inpatient.

2.1.4 Provider shall provide Medically Necessary Covered Services to Members with the same professional standards of care, skill and diligence customarily used by similar physicians in the community in which such services are rendered.

2.1.5 Provider shall render Medically Necessary Covered Services to Members in the same manner, in accordance with the same standards and with the same availability as offered to other patients.

2.1.6 Provider shall comply with all federal and state law relating to Advance Directives.
Provider shall:

- (a) Maintain written policies that address the rights of adult members to make decisions about medical care, including the right to accept or reject medical care, and the right to execute an advance directive. If the provider has a conscientious objection to carrying out an advance directive, it must be explained in the policies.

- (b) Provide written information to adult members regarding each individual's right under state law to make decisions about medical care, and the provider's written policies concerning advance directives (including any conscientious objections).
- (c) Document in the member's medical record whether the adult member has been provided the information and whether an advance directive has been exercised.
- (d) Not discriminate against a member because of his or her decision to execute or not to execute an advance directive, and not make it a condition for the provision of care.
- (e) Provide education to staff on issues concerning advance directives including notification of direct care providers of services, such as home health care and personal care, of any advance directives executed by members to whom they are assigned to provide services.

2.1.7 Provider shall comply with Title VII of the Civil Rights Act of 1964, as amended, the Age Discrimination In Employment Act, State Executive Order 75-5 and Federal Executive Order 11246 which mandates that all persons, regardless of race, color, religion, sex, age, national origin or political affiliation, shall have equal access to employment opportunities. If applicable, Provider shall comply with Section 503 of the Rehabilitation Act of 1973, as amended which prohibits discrimination in the employment or advancement of the employment of qualified persons because of physical or mental handicap. If applicable, Provider shall comply with Title VI of the Civil Rights Act of 1964, which prohibits the denial of benefits of or participation in Covered Services on the basis of race, color or national origin. If applicable, Provider shall comply with the requirement of Section 504 of the Rehabilitation Act of 1973, as amended, which prohibits discrimination on the basis of handicap in delivering Covered Services.

2.1.8 The Contractor shall comply with all federal, state and local immigration laws and regulations relating to the immigration status of their employees during the term of the contract. Further, the Contractor shall flow down this requirement to all subcontractors utilized during the term of the contract. The State shall retain the right to perform random audits of contractor and subcontractor records or to inspect papers of any employee thereof to ensure compliance. Should the State determine that the contractor and/or any subcontractors be found noncompliant, the State may pursue all remedies allowed by law, including, but not limited to, suspension of work, termination of the contract for default and suspension and/or debarment of the Contractor.

2.1.9 Provider shall comply with federal regulations of the Occupational Safety and Health Administration including, without limitation, the regulations concerning Blood Borne Pathogens Standards at 29 C.F.R. Part 1910.1030, as amended.

2.1.10 Provider shall ensure that all handicapped persons have access to Provider facilities as required by applicable federal, state and local law.

2.1.11 If Provider is a PCP as set forth in Exhibit 1, Provider shall coordinate the provision of Medically Necessary Covered Services to Members through the following mechanisms:

- (a) Counsel Members and their families regarding the Member's medical care needs, including family planning and advance directives;
- (b) Initiate referrals for Medically Necessary Covered Services to Plan's contracted Participating Providers, in accordance with generally accepted standards of medical practice in the community and the Provider Reference Manual.

2.1.12 If Provider is a PCP as set forth in Exhibit 1, Provider shall provide preventive health services in accordance with AHCCCS rules and regulations, and Plan policies, as applicable. Preventive health services shall include, but not be limited to:

- (a) Periodic health assessments for all Members twenty-one (21) years of age and over that include major medical, social history and family history within a two (2) year period;
- (b) Immunization and tuberculosis screening (but not immunizations solely for travel) and other measures for the prevention and detection of disease, including instruction in personal healthcare measures and information on proper and timely use of medical resources;
- (c) EPSDT services for all Members up to the age of twenty-one (21) years in accordance with Plan policies and utilizing AHCCCS EPSDT periodicity schedules, tracking forms and specific behavioral health services for certain eligible Members. Provider shall comply with all AHCCCS records and audit

requirements for EPSDT services. EPSDT Periodicity Tables are located in the EPSDT Section of the Provider Manual.

(d) Provider will strive to meet or exceed the AHCCCS Minimum Standard for each Performance Indicator. If the Provider has met or exceeded the Performance Standard, the Provider will strive to meet or exceed the AHCCCS Goal, and then Benchmark. The Plan Quality Improvement Department will measure these Performance Indicators on a yearly basis.

2.2 Capacity and Appointment Availability. To ensure that Provider can provide continued high quality care and adequate access to Members, Provider agrees to maintain the following standards or such subsequent standards adopted by Plan pursuant to Section 9.3 of this Agreement which allows Plan to amend this Agreement.

2.2.1 Each PCP shall accept a panel of no less than 100 Members.

2.2.2 If Provider is a PCP as set forth in Exhibit 1, Provider shall maintain the following appointment availability:

- (a) Same day availability of appointments for emergency care;
- (b) Two (2) day availability of appointments for urgent care; and
- (c) Twenty-one (21) day availability of appointments for routine physical exams or health maintenance visits.

2.2.3 If Provider is an SCP as set forth in Exhibit 1, Provider shall maintain the following appointment availability:

- (a) Within 24 hours of referral for emergency care;
- (b) Within 3 days of referral for urgent care; and
- (c) Within 45 days of referral for routine care.

2.2.4 Wait Times. Wait time for a member in a providers' office shall be no longer than forty-five minutes (45) unless due to an emergency.

2.3 Formulary. If available, Provider shall prescribe generic medications and medications listed in Plan's formulary in accordance with Plan policies. If not available or listed in the formulary, Provider shall obtain approval before prescribing medications in accordance with Prior Authorization policies. Provider understands not all medications are covered by the Plan.

2.4 Provider Facility Locations. Provider shall provide Medically Necessary Covered Services at locations approved by Plan. The approved locations are listed in Exhibit One. Provider shall not add, eliminate or change a location without sixty (60) days advance written notice to Plan and any affected Member and PHP.

2.5 Prior Authorization for Referrals and Other Services. Except for Emergency Medical Services, Provider shall obtain Prior Authorization for specified procedures and shall complete referral forms for Covered Services to be referred to a physician other than Members' assigned PCP, according to Plan policies and procedures. Except for Emergency Medical Services, or as otherwise authorized by the Medical Director (or designee) or required by AHCCCS, all referrals shall be to Participating Providers.

2.5.1 Provider shall initiate referrals at the time Provider determines the need which will enable the Member to receive care (a) within the same day for Emergency Medical Services, (b) within 2 days to receive Urgent Care services, and (c) within 30 days to receive routine care services.

2.5.2 If Provider is not Member's PCP, Provider shall provide to Member's PCP medical information in writing, within thirty (30) days of initial date of service, describing all Covered Services provided to Member.

2.5.3 If Provider is not contracted to provide obstetrical care, Provider shall refer pregnant Members to a participating SCO who is able to provide initial prenatal care appointments within the time requirements of AHCCCS rules and regulations as set forth in Section 2.5.3(d) below.

2.5.4 In the event Provider includes obstetrics within Provider's scope of practice as set for on Exhibit 1, the following provisions shall apply:

- (a) Provider shall have training and experience in obstetrics/gynecology, have completed an approved training program, or be generally recognized by the physician community as being skilled in obstetrical/gynecological practice.
- (b) Provider shall provide medically necessary obstetrical/gynecological Covered Services to members with the same standard of care, skill and diligence customarily used by licensed Obstetricians/Gynecologists in the community in which such services are rendered.
- (c) Provider shall obtain Prior Authorization in accordance with the Plan's list of obstetrical services requiring Prior Authorization/Notification.
- (d) Provider shall make provisions and schedule appointments for enrolled pregnant Members to obtain initial and ongoing prenatal care within the following time framework:
 - (i) First trimester – within fourteen (14) days of a request for an appointment.
 - (ii) Second trimester – within seven (7) days of a request for an appointment.
 - (iii) Third trimester – within three (3) days of a request for an appointment.
 - (iv) High risk prenatal care shall be initiated within three (3) days of identification of high risk, or immediately if an emergency exists.
 - (v) Provider shall schedule office visits during an uncomplicated pregnancy based upon the following recommended standards promulgated by the American College of Obstetrics and Gynecology (ACOG): every four (4) weeks for the first twenty-eight (28) weeks of pregnancy; every two (2) – three (3) weeks until thirty-six (36) weeks of gestation; and weekly thereafter.
 - (vi) Provider shall maintain responsibility for care for sixty (60) days after delivery with a minimum of one (1) postpartum visit at approximately six (6) weeks postpartum.
 - (vii) Provider shall schedule high risk patients as appropriate to their individual needs.
- (e) Provider, upon the receipt of a PCP referral for continued obstetrical care, shall report the referral to the Plan patient coordinator (the "Coordinator") within two (2) working days. Provider shall report all multiparity pregnancies to the Coordinator within one (1) week of identification of multiparity. PCP Providers providing continued obstetrical care shall report any pregnancy to the Coordinator within (2) working days and shall report all multiparity pregnancies to the Coordinator within one (1) week of identification of multiparity.
- (f) Referrals by PCPs to Provider are valid through the termination of pregnancy and for the number of days postpartum required by AHCCCS or the applicable Commercial Plan, provided Member has continued Plan enrollment.
- (g) Provider may refer Members to a Plan participating perinatologist for consultation and/or continued obstetrical care upon Prior Authorization from Plan.
- (h) Provider shall cooperate with perinatal case management and other perinatal support programs that may be authorized by Plan.
- (i) Plan shall pay Provider for the provision of all Medically Necessary obstetrical Covered Services as provided in Exhibit 4B.

2.6 Staff Membership at Participating Hospitals.

2.6.1 Provider shall maintain staff membership and admission privileges in good standing with at least one of the hospitals with which Plan has contracted as a Participating Provider; or have a Hospitalist Agreement with at least one of the hospitals with which the plan has contracted as a Participating Provider, or as otherwise permitted by Plan.

2.6.2 Provider shall admit Members only to contracted Hospitals except (a) as otherwise approved by Plan; (b) if Emergency Medical Services are required; (c) as otherwise described in the Provider Reference Manual; or (d) as otherwise required by law or AHCCCS regulation.

2.7 Utilization Management

2.7.1 Provider shall comply with and cooperate in Plan's Utilization Management review activities as set forth in Section 3.6.

2.7.2 Plan may conduct medical and utilization review of claims submitted by Provider to ascertain Medical Necessity and appropriateness of costs.

2.7.3 Provider shall designate appropriate personnel to facilitate Plan's Utilization Management reviews (including Prior Authorization, concurrent and retrospective review) and Quality Management. Provider shall provide Plan with timely access to Member's medical records to facilitate Utilization Management review and Quality Management.

2.7.4 Provider shall compile and provide utilization and quality review information to Plan, subject to applicable laws, in a manner intended to assess and enhance performance with regard to quality of care, quality of service and cost effectiveness as required by Plan and AHCCCS.

2.8 Quality Management Compliance. Provider shall comply with the Plan Quality Management program and other programs as may be adopted by Plan, and the National Committee for Quality Assurance (NCQA), or required by regulatory agencies such as AHCCCS or HCFA. Provider shall allow Plan or its agents to conduct periodic audits and site surveys upon reasonable notice and during regular office hours for the purpose of evaluating compliance with Quality Management standards.

2.9 Licensure and Credentialing

2.9.1 Provider shall comply with, and shall ensure that all PHP's, if any, comply with, Plan's standards and procedures regarding the credentialing and approval of Provider and PHP's for participation under this Agreement. Provider shall comply with, and shall ensure that all PHP's comply with, all federal and state laws and regulations regarding licensure, Medicare and AHCCCS certification and Drug Enforcement Administration number(s) and Plan requirements regarding credentialing.

2.9.2 Provider shall give immediate written notice to Plan if Provider or any PHP's license to practice or ability to participate in AHCCCS Plans is lost, suspended or limited in any way that affects Provider or PHP's ability to provide services under this Agreement. Provider shall furnish to Plan such evidence of hospital privileges, malpractice history, licensure history, and specialty certifications as Plan may request.

2.9.3 If Provider is licensed, certified or accredited by an agency, such as the Occupational Safety and Health Administration (OSHA) or Clinical Laboratory Improvement Act (CLIA), Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), National Committee on Quality Assurance (NCQA) or AAHC, Provider shall furnish such evidence of licensure, certification or accreditation to Plan. Provider shall give immediate written notice to Plan if such licensure, certificate or accreditation is lost, suspended or limited in any way.

2.9.4 Provider and PHP's shall at all times be registered with AHCCCS as an authorized AHCCCS provider in good standing. Provider may not provide or bill for services if not registered with AHCCCS.

2.9.5 Complaint, Inquiry, Investigation or Review. Provider shall notify Plan immediately of the initiation of any lawsuit, complaint, inquiry, investigation, review or action by any licensing or regulatory authority, organization or body which directly or indirectly evaluates or focuses on the quality of care provided by Provider or Affiliated Physicians, either in any specific instance or in general, or which may, if sustained, materially impede Provider or PHP's ability to meet its duties and obligations under this Agreement.

2.10 Member Eligibility. Pursuant to the procedures set forth in Plan Policy, and based on eligibility lists supplied to Provider by Plan and the eligibility verification procedure set forth in Section 3.1 below, Provider shall determine whether Members are eligible for Covered Services. It is Provider's responsibility to verify the enrollment and assignment of all Members with Plan on the date of service, and failure to do so may result in a claim being denied. Receipt of an approved referral does not verify member's eligibility at the time of service with the Provider.

2.10.1 Provider will notify Plan of any Member activity that causes suspicion of fraud against the Plan.

2.11 New Members. Provider shall accept all Members who select that Provider as their PCP. Panel size is to be no less than 100 members.

2.12 Panel Closure – Member Access. Provider shall not close a patient panel without sixty (60) days' advance written notice to Plan and without written approval of Plan. Provider will comply and cooperate with all requests for records needed to transition members to other providers in accordance with Plan and AHCCCS policy.

2.13 Management and Services Responsibilities. The operation and maintenance of the offices, facilities and equipment of Provider and the provision of all Covered Services, shall be solely and exclusively under the professional control and supervision of Provider. Plan shall have no right of control over the selection of support staff, the supervision of personnel, or the financial operation of Provider's practice. Nothing contained in this Agreement shall be construed as giving Plan any right to manage or conduct the practice of Provider as manager, proprietor, lessor or otherwise. The Provider is required to meet all AHCCCS Plan requirements for facilities and member services.

2.14 Prohibitions on Member Billing. Provider agrees that in no event, including, but not limited to, nonpayment by Plan, Plan's insolvency or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Member or persons other than Plan acting on a Member's behalf for Covered Services provided pursuant to this Agreement. This provision shall not prohibit collection of Copayment in accordance with the terms of Arizona Administrative Code, Title 9, Chapter 22, R9-22-711 as amended. However, Provider shall not refuse to provide Covered Services to members who are unable to pay a Copayment. Provider further agrees that (a) this provision shall survive the termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of the Member, and (b) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and Member or persons acting on their behalf.

2.14.1 Non-covered services may be billed to the Member only if a waiver has been signed by the member and all costs associated with the services have been disclosed in advance to the Member. The Member must understand that the service will not be covered by the Plan.

2.15 Encounter Claims/Utilization Data. Provider shall submit a claim for all covered services, whether capitated or not, per CMS guidelines including the Vaccine For Children Program immunizations for all members for whom Provider receives payments. Such claims data shall be submitted on a CMS 1500 form within ninety (90) days after the Covered Services are rendered. Claims data elements shall include, but not be limited to the items set forth in Section 2.2 on Exhibits 3 and 4 to ensure Plan is in compliance with all AHCCCS reporting requirements related to claims data.

2.15.1 Plan reserves the right to audit provider's billing procedures and claims at any time, and provider agrees to fully cooperate and provide necessary records for such audit.

2.15.2 Provider agrees to have procedures in place that will insure proper coding, billing, and documentation is occurring within the Provider office.

2.16 Orientation. Provider or designee shall attend a Plan orientation. In addition the provider or designee are required to attend one (1) Provider Update meeting per year with the Plan Medical Director. If the provider chooses to send a designee, the Provider is responsible for all information disseminated, written or oral, at Orientation and Provider Update meetings.

2.17 Laws, Rules and Regulations; Policies and Procedures. Provider shall comply with all laws relating to AHCCCS and all AHCCCS regulations, provisions or policies, and Plan rules and regulations, policies and procedures governing performance of duties under this Agreement, including those in the AHCCCS Standard Subcontract Terms and Conditions attached as Exhibit 5. Provider shall comply with all federal, state and local laws, regulations, standards and executive orders governing performance of duties under this Agreement, including, but not limited to, all provisions relating to Provider participation in AHCCCS, prohibitions on kickbacks or improper practices under 42 U.S.C. § 1320a-7 et seq. and 42 U.S.C. § 1395nn (the Anti-Fraud and Abuse and Stark Laws) and provisions for physician incentive arrangements pursuant to 42 U.S.C. § 1395mm(i) and related regulations. Provider will appropriately report all incidents of suspected child and vulnerable adult abuse to proper authorities and to Plan.

2.18 Facility Inspection. Provider shall allow Plan or its agents to inspect Provider premises and operations upon reasonable notice and during regular office hours to ensure that such premises and operations are adequate to meet Member's needs. The facility will be inspected prior to the Provider beginning to see patients.

2.19 Member Information. All information about and concerning Members, including their names and addresses ("Information") is considered confidential and proprietary to Plan. Except as otherwise required by Section 5, as is Medically Necessary or as required by the physician-patient relationship, Provider shall not use any Information or contact Members without the advance written consent of Plan. Changes in practice (location, PHP termination with

Provider, etc) must all be communicated to the Member by the Plan. The provisions of this Section 2.19 shall survive the termination of this Agreement. Nothing in this Section shall be construed to limit communications between Provider and Members necessary for the provision of Covered Services.

2.20 Data Exchange Requirement. Provider shall meet any AHCCCS Plan required technical and procedural requirements for data exchange interfaces between or among AHCCCS, Plan and Provider. Provider shall comply with any technical requirements as mandated by AHCCCS from time to time. Provider shall implement any applicable ANSI electronic data interchange ("EDI") standards required by AHCCCS or the Plan.

2.21 Cultural Competency. All providers must offer high quality services in a culturally competent manner. In providing this care, the provider must be aware of and sensitive to the patient's cultural needs. Factors that influence culture include but are not limited to: race, ethnicity, where one was raised, language, age, gender, socioeconomic status, religion, values and beliefs, family structure, sexual orientation, homelessness, physical and mental ability.

2.22 Interpretative Services. The Plan, in conjunction with the provider, shall provide interpretive services to those members needing such services. If the provider is aware that a member is in need of interpretive services, the provider shall assist the member in contacting the Plan to arrange for these services.

SECTION 3. RIGHTS, RESPONSIBILITIES AND OBLIGATIONS OF PLAN

3.1 Administration. Plan agrees to administer the provisions of this Agreement according to AHCCCS requirements. This includes Prior Authorization, Utilization Management, Quality Management, Member Services, Provider Services, fiscal services, claims processing and information reporting.

3.1.1 Member Eligibility Verification. Plan shall maintain a 24-hour per day, seven day a week telephone or on-line service to assist Provider in verifying the eligibility of a Member.

3.1.2 Eligibility List. Plan shall provide to Provider monthly a list of all Members eligible to receive Covered Services under this Agreement who have selected Provider or a PHP as their PCP.

3.2 Orientation, Education and Communication. Plan will assign a Provider representative to provide initial orientation, ongoing education and operational assistance to Provider regarding participation with Plan.

3.3 Policies and Procedures. Plan shall develop and maintain policies and procedures and shall make copies of these policies, procedures and the Provider Reference Manual available to Provider. During the term of this Agreement, Plan shall notify Provider of any modifications to the policies and procedures.

3.4 Compensation

3.4.1 Provider. Plan shall compensate Provider for Medically Necessary Covered Services delivered under this Agreement as set forth in Exhibit 3 (pertaining to PCP Compensation) or Exhibit 4 (pertaining to Specialty Compensation). Provider shall accept the compensation set forth in this Agreement and Exhibits 3 and 4, including the coordination of benefits provisions, less applicable Copayments, deductibles and coinsurance, as payment in full for all Covered Services provided by Provider to Members pursuant to this Agreement. Plan shall have no obligation or responsibility to make any compensation directly to any PHP.

3.4.2 Back-up Coverage. Provider shall compensate Replacement Physician who, upon the request of Provider, provides Medically Necessary Covered Services included under the Capitation Payment set forth in Exhibits 3 or 4. Payment for these services shall be decided between Provider and Replacement Physician, and is not the financial responsibility of Plan. The Replacement Physician shall fulfill all Prior Authorization and reporting requirements of Provider.

3.5 Utilization Information. Plan will compile and provide utilization review information to Provider in a manner intended to assess and enhance performance with regard to quality of care, quality of service and cost effectiveness.

3.6 Utilization Management. Plan or its designee shall perform Utilization Management services, including but not limited to, the following:

3.6.1 Selective Prospective Review. Through its Prior Authorization process, Plan shall confirm Member's eligibility and ensure proposed services are Medically Necessary Covered Services and are provided at the most appropriate level of care and site.

3.6.2 Inpatient Case Management. Plan's reviewers for Inpatient Services shall provide on-site or telephonic nurse reviewers for Utilization Management and discharge planning.

3.6.3. Outpatient Case Management. Plan's case reviewers for Outpatient Services shall assess, plan, coordinate, monitor and evaluate options and care relating to Outpatient Services to meet a Member's health needs.

3.6.4 Retrospective Review. Plan may conduct retrospective review of all Covered Services including Inpatient, Outpatient, Emergency Services provided by Provider and any PHP to determine appropriateness and medical necessity of such services. If review shows provision of inappropriate, not medically necessary services, recoupment may occur.

SECTION 4. JOINT OBLIGATIONS

4.1 Relationship.

4.1.1 Independent Contractors. This Agreement is not intended to create nor shall be construed to create any relationship between Plan and Provider other than that of independent contractors. Neither Plan nor Provider is acting as the agents, employers, employees or representatives of the other.

4.1.2 Nothing in this Agreement, including Provider's participation in the Quality Management and Utilization Management programs, shall be construed to interfere with or in any way affect Provider's obligation to exercise independent medical judgment in rendering Covered Services to Members.

4.1.3 Provider and its employees and independent contractors shall be solely responsible for the payment of any and all taxes, penalties, assessments and interest thereon which may be due or assessed by any governmental entity or agency, and shall hold Plan, AHCCCS harmless therefore, which taxes, penalties, assessments and interest may arise out of monies earned, collected, paid to or charged by Provider for Covered services rendered to Members.

4.1.4 No educational program or audit process shall be construed to substitute for provider's responsibility for their own actions and/or interpretation of such educational materials.

4.2 Member Grievances and Request for Hearing. Provider acknowledges receipt of the Plan grievance procedure for Plan Members and shall cooperate with Plan in the implementation of that procedure and shall assist Plan in taking appropriate corrective action. Provider agrees to comply with all final determinations pursuant to AHCCCS, Plan grievance policies and procedures, as applicable. Within five (5) days of receipt of a grievance, Provider shall provide Plan with a copy of that grievance and the Provider's written response.

4.2.1 Provider agrees to conduct a good faith investigation of all Member complaints, to make every effort to resolve complaints informally, and to notify Plan promptly of any Member grievances known by Provider.

4.2.2 Each party shall promptly notify the other in writing of any claim or lawsuit which has been asserted or is suspected or anticipated which involves a Plan Member or which may affect the other party.

SECTION 5. RECORDS

5.1 Member Records. Provider shall maintain records and information including, but not limited to, medical records for Members related to the provision of Covered Services to Members, billed charges, payments received by Provider from Plan or Members, and all records described in Exhibit 5 (collectively, the "Records"), in accordance with general standards applicable to such records.

5.1.1 Provider shall make the Records available to other medical providers, subject to applicable confidentiality requirements, when such Records are necessary for treating a Member. Provider shall retain all Records for a minimum of ten (10) years from the date of service.

5.1.2 During the term of this Agreement and at any time thereafter that such access is reasonably required in connection with a Member's health care or review of Provider's compliance under this Agreement, Provider shall provide Plan or its designee, or its designee and AHCCCS or designee with reasonable access during regular business hours to the Records maintained by Provider. Provider shall allow Plan or its designee, and AHCCCS or designee reasonable access to review, copy or obtain specified records or documents at no charge. Further, Provider agrees to furnish to Plan at no charge copies of all medical records, x-rays, laboratory reports or any other patient care information within ten (10) working days of receipt of request.

5.1.3 Provider shall maintain and furnish such records and documents, both medical and non-medical, as required by applicable federal and state laws, rules and regulations including if applicable 42 U.S.C. §1395x(v)(1)(l) and Plan medical record standards and as specifically required by Arizona Administrative Code, Title 9, Chapter 22, R9-22-402 (10) as amended. Provider agrees to cooperate with Plan to facilitate the record and information exchanges necessary for the Quality Management program, Utilization Management, peer review, billing compliance, or other programs required for Plan, or AHCCCS operations.

5.2 Confidentiality. Plan and Provider agree that medical records of Members, as well as quality and utilization management records, shall be regarded as confidential and both shall comply with all applicable federal and state laws and regulations regarding such records, including Arizona Administrative Code, Title 9, Chapter 22, R9-22-402 (11), as amended.

SECTION 6. TERM OF AGREEMENT, RENEWAL AND TERMINATION

6.1 Term of Agreement. This Agreement shall begin on the effective date set forth above and shall continue for two (2) years unless continued or terminated as set forth below.

6.2 Renewal. This Agreement shall be automatically renewed under the same terms and conditions for additional two (2) year terms unless either Plan or Provider gives written notice to the other no less than sixty (60) days before the expiration of the Term or any renewal Term.

6.3 Termination.

6.3.1 For Cause. Provider or Plan may terminate this Agreement at any time for cause. Cause includes, but is not limited to:

- (a) Failure of Plan to secure an AHCCCS contract or cancellation, termination or material modification of Plan's contract with AHCCCS.
- (b) Failure of Plan to make required payments to Provider.
- (c) Initiation of bankruptcy proceedings by or against either party.
- (d) Material breach of this Agreement by either party.
- (e) Failure by Provider to maintain licenses, federal certification, designation or registration required to perform Provider's duties under this Agreement, or to comply with applicable laws or regulations.
- (f) Any misrepresentation or falsification of any information on any PHP's application and/or any other relevant document provided by Provider to Plan.
- (g) Any suspension, termination, limitation or reduction of any Provider's privileges at any hospital or any Provider's failure to obtain or remain in good standing for privileges at a hospital.
- (h) Commission or omission of any act or any conduct or allegation of conduct for which any Provider's license or ability to participate in Medicare or AHCCCS may be subject to revocation, suspension or limitation, whether or not actually revoked, suspended or limited, or if Provider is otherwise disciplined by any licensing, regulatory, professional entity, or any professional organization with jurisdiction over Provider.
- (i) Failure of any Provider to maintain required insurance and liability coverage protection, or failure of Provider to maintain such coverage on behalf of any PHP.
- (j) Commission or omission of any act or conduct by Provider which is detrimental to a Member's health or safety as determined by Plan.
- (k) Billing, coding, and/or documentation which do not comply with relevant Medicaid guidelines, relevant state requirements, and/or relevant Plan requirements.

(l) Failure of provider to meet with Plan representatives upon reasonable Request to discuss any/all Plan requirements.

Any occurrence under paragraphs (e) through (l) above shall be grounds for immediate termination of PHP. Termination for any other reason set forth above shall be upon thirty (30) days advance written notice by the terminating party.

6.3.2 Without Cause. This Agreement may be terminated at any time without cause or prejudice upon ninety (90) days advance written notice by either party.

6.4 Rights and Obligations Upon Termination. Upon termination of this Agreement, regardless of cause or reason, AHCCCS shall be notified and all rights and obligations of the parties relating to services during the term of and under this Agreement shall survive the termination.

6.4.1 Upon termination, Provider's obligations or right to render Covered Services to Members or right to receive payment in accordance with this Agreement shall immediately cease, except for any payments due before such termination. Notwithstanding anything contained herein to the contrary, Plan shall continue to pay Provider in accordance with the provisions of this Agreement for Medically Necessary Covered Services provided by Provider to any Members required for continuity of care or hospitalized at the time of termination of this Agreement, pending discharge or transfer of such Member to a Plan Participating Hospital when medically appropriate as determined solely by Plan. In continuing to provide such Covered Services, Provider shall abide by the applicable terms and conditions of this Agreement.

6.4.2 Provider shall refund that portion of Capitation Payments, if any, received by Provider applicable to periods following termination of this Agreement. In addition, Provider shall refund to Plan any monies paid for Covered Services not rendered or not delivered in compliance with applicable laws, rules and regulations.

6.4.3 Provider has no obligation under this Agreement to provide services to individuals who cease to be eligible and enrolled Members nor does Plan have any obligation to make payment for any services provided to such individuals.

6.4.4 Upon termination of this Agreement for any reason, the rights of each party under this Agreement shall terminate. Any such termination, however, shall not release Provider or Plan from obligations under this Agreement in effect before the effective date of termination.

SECTION 7. INSURANCE AND LIABILITY

7.1 Insurance. Provider shall be responsible for providing all health, accident, workers' compensation, general liability and other appropriate insurance for Provider and all PHP's (including employees) in connection with or under this Agreement. Provider shall provide Plan with certificates of insurance annually.

7.2 Provider Professional Liability. Throughout the term of this Agreement, Provider shall maintain at Provider's expense, for Provider and all PHP's, if any, general and professional liability coverage in a form and amounts acceptable to Plan. At a minimum coverage will be \$1,000,000 per occurrence and \$3,000,000 in aggregate. Certificates of insurance to be provided to the Plan annually. In the event such coverage is claims-made insurance, Provider shall maintain such coverage continuously, and in the event of PHP leaving Provider, or termination of this Agreement, Provider shall secure, or require each such PHP to secure, tail coverage with agreed limits of liability to provide continuous coverage for the period of the relevant statute of limitations for any claims that may arise against Plan as a result of the act or omission of Provider or any PHP under this Agreement. Provider shall give Plan thirty (30) days prior written notice of cancellation, modification or termination of any such insurance. Provider shall give Plan prompt written notice of any claims against Provider's or any PHP's professional liability coverage.

7.3 Indemnification. Provider shall hold harmless the State of Arizona, all State officers and employees, AHCCCS and employees of AHCCCS and all AHCCCS members in the event of nonpayment by Plan to Provider. Provider shall further indemnify and hold harmless Plan, its officers and directors, the State and AHCCCS, and their agents, officers and employees, against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses (including attorneys' fees) which may in any manner accrue against Plan, the State or AHCCCS, or their agents, officers or employees, through the intentional conduct, negligence or omission of Provider, its agents, officers, employees or contractors, arising out of or relating to this Agreement or the provision of Covered Services under this Agreement. Provider agrees that Plan, its officers and directors, the State and AHCCCS, and their agents, officers and employees shall have no responsibility or liability for any such taxes or insurance coverage described in this Agreement.

7.4 Survival. The provisions of this Section 7 shall survive the termination of this Agreement.

SECTION 8. REPRESENTATIONS

8.1 Provider Representation. Provider represents and warrants that the information set forth in the Plan Provider application is true and correct and that all such information regarding PHP's, if any, is true and correct. Provider shall promptly notify Plan in writing of any changes in the information contained in the application within thirty (30) days of such change.

8.2 Member Guarantees. Plan makes no representations or guarantees concerning the number of Members it can or will refer to Provider under this Agreement. Plan reserves the right to direct business to selected PHPs at specified medical facilities or in specified geographic areas.

8.3 Marketing and Signage.

8.3.1 Provider agrees that Provider's and each PHP's name, office telephone number, address, specialty, board certification, hospital affiliation, education, schools attended, language fluency and special interests may be included in literature distributed by Plan to existing or potential Members and Participating Providers.

8.3.2 Plan may use Provider's and each PHP's name and affiliation with Plan in advertising, promoting and soliciting Members in an effort to increase membership and to otherwise carry out the terms of this Agreement and Plan's contract with AHCCCS.

8.3.3 Except as set forth above, Provider's or PHP's use of Plan's name, or of Provider or PHP's name by Plan, shall be upon advance written consent, such consent not to be unreasonably withheld.

SECTION 9. GENERAL PROVISIONS

9.1 Assignment and Delegation of Duties. Neither Plan nor Provider may assign duties, rights or interests under this Agreement without the advance written approval of the other party and AHCCCS; provided, however, that any reference to Plan shall include any successor in interest and that Plan may assign its duties, rights and interests under this Agreement in whole or in part to a Plan affiliate, subsidiary or other entity controlled by Plan or may delegate any and all of its duties in the ordinary course of business, subject to AHCCCS laws, rules and regulations.

9.2 Interpretation. This Agreement shall be governed by and construed in accordance with all applicable federal and Arizona laws, rules and contractual obligations of Plan.

9.3 Amendments. Plan may amend this Agreement, the exhibits and the Provider Reference Manual by providing advance written notice to Provider and AHCCCS in accordance with applicable policies and procedures as established by Plan and AHCCCS.

9.3.1 Failure of Provider to object in writing to any such proposed amendment within thirty (30) days following receipt of notice shall constitute Provider's acceptance of the amendment.

9.3.2 In the event that state or federal law or regulations should change, alter or modify the present services, levels of payments to Plan, standards of eligibility of Members, or any operations of Plan, such that the terms, benefits and conditions of this Agreement must be changed accordingly, then upon notice from Plan, Provider shall continue to perform services under this Agreement as modified.

9.3.3 In the event that any updates or revisions to the most current HCFA Common Procedure Coding System (HCPCS), Current Procedural Terminology (CPT) or International Classification of Diseases (ICD)-9 Codes should occur during the term of this Agreement, Provider agrees to employ the most recent update or revisions without request by Plan.

9.4 Exhibits. The Exhibits are a part of this Agreement and their terms shall supersede those of other parts of this Agreement in the event of a conflict.

9.5 Entire Agreement. This Agreement, its Exhibits and the documents referred to in this Agreement constitute the entire agreement between the parties, and supersede all other understandings, express or implied, oral or written.

9.6 Notice. Any notice required under this Agreement shall be in writing and shall be sent by United States mail, postage prepaid, to the Executive Director of Plan at:

University Physicians Health Plans
Executive Director

2701 E. Elvira Rd
Tucson, Arizona 85756

and to Provider at the first address set forth on the signature page of this Agreement. The date of receipt shall be five (5) calendar days from the date of mailing.

9.7 Enforceability and Waiver. The invalidity and non-enforceability of any term or provision of this Agreement shall in no way affect the validity or enforceability of any other term or provision. The waiver by either party of a breach of any provision of this Agreement shall not operate as or be construed as a waiver of any subsequent breach thereof.

9.8 Regulatory Approval. In the event that Plan has not been licensed or has not received any applicable regulatory approval for use of this Agreement prior to the execution of this Agreement, this Agreement shall be deemed to be a binding letter of intent. In such event, the Agreement shall become effective on the date that such regulatory approval is obtained. If Plan is unable to obtain such licensure or approval after due diligence, Plan shall notify Provider and both parties shall be released from any liability under this Agreement; provided, however, that if such licensure or approval is obtained upon the condition of Plan's amendment of this Agreement, then this Agreement shall continue and Plan shall amend pursuant to Section 9.3.

9.9 Dispute Resolution. All disputes under this Agreement shall be resolved through the relevant AHCCCS dispute resolution procedures, including but not limited to those set forth in Arizona Administrative Code, Title 9, Chapter 22, R9-22-804, or the Plan's Member Grievances Policy and Procedure, depending upon whether the Member is enrolled in AHCCCS.

SECTION 10. CONFIDENTIALITY OF THIS AGREEMENT AND PLAN OPERATIONS

Unless otherwise required by AHCCCS or other rules or regulations, the terms and conditions of this Agreement, including financial rates and information relating to Plan operations, are proprietary information and shall not be disclosed or disseminated by Provider or any of its agents or representatives whether during negotiation, during the term of this Agreement, or after its termination.

SECTION 11. PROVIDER APPEALS AND REQUEST FOR STATE FAIR HEARING

11.1 Right to File an Appeal and Request for State Fair Hearing. The Provider has the right to file an Appeal and Request for State Fair Hearing in response to any adverse action or decision made by the Plan. Both the Provider and the Plan agree to attempt to resolve the disputes informally prior to initiating a formal appeal. If the Parties are unable to reach a resolution, both the Provider and the Plan agree to follow the appeals process defined by AHCCCS Arizona Administrative Code R9-22-801 et. seq.

11.2 The Appeals Process.

11.2.1 Non-claims issue. A Provider has the right to file an appeal on any adverse decisions or actions made by the Plan. An Appeal must be submitted to the Plan in writing within sixty (60) days of the adverse action/decision and must include the requestor's name, address, telephone number, the member name, identification number, the adverse action and an explanation as to the reason for filing.

Once the Provider has submitted a written appeal to the Plan, the Plan will send an acknowledgement letter within five (5) days by certified mail. The Plan will respond to all appeals within thirty (30) days from the date the Plan receives the appeal. The Plan will mail a final written decision by certified mail. The decision letter will clearly specify the nature of the appeal, issues involved, the contractual provisions, or policies and an explanation of the complainant's right to Request for State Fair Hearing decision to AHCCCS Administration, in writing, no later than thirty (30) days following the date of the final decision. This information will be provided to the complainant regardless of whether the decision is reversed or upheld. If an extension is necessary, the Plan will forward the notification.

11.2.2 Claims Issues. All provider resubmissions challenging claims denials will be processed through the Claims Department Customer Service Representative as a resubmission with a final decision within thirty (30) calendar days. If after the resubmission decision the provider is dissatisfied, a formal appeal may be submitted. The Provider must notify the Plan in writing. The Provider may submit a claims appeal within twelve (12) months from the date of service, twelve (12) months after the date of eligibility posting or within sixty (60) days after the date of a timely submission, whichever is later. All claims appeals from providers will be researched and a final decision will be rendered within thirty (30) days. The provider must include a copy of the claim and supporting documentation for the billed charges.

11.2.3 How to File an Appeal. All formal Appeals should be submitted in writing to the Plan Appeals Manager at the address listed below:

University Physicians Health Plans
Attention: Appeals Manager
2701 E. Elvira Rd
Tucson, AZ. 85756

The following documentation must be submitted with the written grievance:

- Cover letter stating the problem and a proposal for resolving the dispute;
- Provider name, address, phone number and a description explaining the grievance;
- A copy of the claim (if billing issue); and
- A copy of all supporting documentation to support the billed charges
- Member name and Identification Number

11.3 Filing a Request for State Fair Hearing Decision. If the Provider is not satisfied with the appeal decision, the provider may file a written notice for a Request for State Fair Hearing. The Request for State Fair Hearing notice must be received by the Plan within thirty (30) calendar days from the date of the postmark of the appeals decision. The Request for State Fair Hearing only needs to state that the requestor does not agree with the decision. The Plan will forward a copy of the Request for State Fair Hearing and the Plan's file to the State AHCCCS Office of Appeals and State Fair Hearings within five (5) working days. AHCCCS will either issue an informal decision or schedule a hearing. The provider filing a request for hearing will need to appear at the hearing in person or telephonically. A hearing date will be scheduled by AHCCCS.

(Remainder of this page left blank intentionally)

IN WITNESS WHEREOF, the parties hereto have executed and delivered this Agreement as of the effective date.

**UNIVERSITY PHYSICIANS HEALTHCARE
dba UNIVERSITY PHYSICIANS HEALTH PLANS**

Date: 9/8/09

By: *Kathleen Oestreich*
(Signature)

Kathleen Oestreich
(Please print or type name)

Title: Chief Executive Officer

Gila County Health Department

Date: 10/6/09

By: *Shirley Dawson*
(Signature)

Shirley Dawson
(Please print or type name)

Title: Chairman, Board of Supervisors

NPI # 1700941507 (Globe)
1760547566 (Payson)

AHCCCS ID # 479718 (Globe)
486250 (Payson)

Federal Tax I.D. Number: 86-6000444

Tax I.D. Registered Name: Gila County

Telephone Number: 928-425-3231

Fax Number: 928-425-0794

Billing Address: 5515 S Apache Ave Ste 100
Globe, AZ 85501

Approved as to form
Bryan B. Chambers
Chief Deputy County Attorney

**EXHIBIT SCHEDULE
For
Gila County Health Department**

Exhibits Included in this Contract are marked with an "X"

Providers:

- Exhibit 1 Provider Identification
- Exhibit 3 Compensation – Primary Care
- Exhibit 3A Payment Schedule – Primary Care
- Exhibit 4 Compensation – Specialist
- Exhibit 4B Compensation – Obstetrics
- Exhibit 4C Compensation – Radiology
- Exhibit 5 AHCCCS Subcontract Provision (all providers)
- Exhibit 6 University Physicians Care Advantage (all providers)

Facilities:

- Exhibit 1 Provider Identification
- Exhibit 2 Facility Compensation
- Exhibit 3 Scope of Services
- Exhibit 5 AHCCCS Subcontract Provision (all providers)
- Exhibit 6 University Physicians Care Advantage (all providers)

Ancillary:

- Exhibit 1 Provider Identification
- Exhibit 2 Ancillary Compensation
- Exhibit 2A Fee Schedule
- Exhibit 4C Compensation – Radiology
- Exhibit 5 AHCCCS Subcontract Provision (all providers)
- Exhibit 6 University Physicians Care Advantage (all providers)

Hospital:

- Exhibit 1 Provider Identification
- Exhibit 2 Compensation
- Exhibit 3 Scope of Service
- Exhibit 5 AHCCCS Subcontract Provision (all providers)
- Exhibit 6 University Physicians Care Advantage (all providers)

**EXHIBIT 1
FOR
Gila County Health Department**

Check One:

- Provider is Primary Care Physician
- Primary Care Physician including Obstetrics
- Specialty Care Physician (Specialty: _ _ _ _ _)
- Specialty Care Obstetrician
- Ancillary Service Provider _____
- Other _____

List of all Participating Health Providers (PHP) and Practice Areas to provide Covered Services under this Agreement:

<u>Name</u>	<u>Practice Specialty</u>	<u>AHCCCS ID#</u>	<u>NPI #</u>
Michael R Durham MD	General Pediatrics	046559	1730130022

List all locations for Provider under this Agreement:

5515 S Apache Ave Ste 100
Globe, AZ 85501

107 W Frontier Ste A
Payson, AZ 85541

Phone (928) 402-8812
Fax (928) 425-0794

NOTE: Provider must notify plan of additions or changes in locations and providers, to get paid for services.

*** If additional space is needed, please attach a sheet indicating providers and locations. Please indicate on the exhibit that there is an additional attachment.

EXHIBIT 3
COMPENSATION – PRIMARY CARE PHYSICIAN
For
Gila County Health Department

THIS EXHIBIT 3 ONLY APPLIES TO THOSE PROVIDERS CLASSIFIED AS
PRIMARY CARE PHYSICIANS AS INDICATED IN EXHIBIT 1

SECTION 1. METHOD OF PAYMENT

1.1 Fee-for-Service Services. Plan will reimburse Provider on a fee for service basis according to the fee schedule in 1.1.1. and 1.1.2, less applicable copayments, for Medically Necessary Covered Services provided to Member. Plan shall pay Provider for these services if such services are Medically Necessary and Prior Authorized by the Plan, based upon the lesser of the billed charge or the Plan fee schedule.

1.1.1 University Family Care and KidsCare enrollees, Plan Fee Schedule is ninety percent (90%) of the AHCCCS fee schedule less applicable copayment, coinsurance and deductible as determined by the AHCCCS Administration. Upon complying with the Notice requirements of Section 9.4 in the Agreement, Plan reserves the right to change the percentage indicated above at its discretion. In the event that a procedure is not listed on the AHCCCS fee schedule, or the service is not assigned an amount, Plan will reimburse Provider at sixty-five percent (65%) of billed charges, whichever is less, not to exceed usual, reasonable, and customary charges, less any applicable copayment, coinsurance and deductible. No payment will be made for Covered Services that are determined to be unallowable, excessive or inappropriate after retrospective review by Plan.

Usual, reasonable, and customary means the usual charge made by a physician or supplier of services, medicine, or supplies. This fee will not exceed the general level of charge determined by others rendering or furnishing such services, medicines, or supplies within an area in which the charge is incurred for sickness or injuries comparable in severity and nature to the sickness or injury being treated. The term "area", as it would apply to any particular service, medicine, or supply, means a county or such greater areas as is necessary to obtain a representative cross section of level of charges.

1.2 Ineligible Covered Persons: Negative Retroactivity. In the event Plan determines, at any time, that a Member is ineligible or terminated from coverage by AHCCCS or the Plan, Provider shall return to Plan any capitation or fee for service payments paid by Plan for that Member on or after the effective date of Member's termination or ineligibility. Provider may seek payment for Medically Necessary Covered Services provided to an ineligible or terminated Member after loss of eligibility or the termination date from either a new third party payor or from the individual.

1.3 Prior Authorization. Provider must receive Prior Authorization from Plan for any fee-for-service Medically Necessary Covered Services provided to the Member in accordance with Plan policies. Failure to follow Plan's Prior Authorization/Notification policy may result in denial of payment. Prior authorization is not a guarantee of payment. Provider must meet all terms and conditions of provision of care, documentation, and billing.

1.4 In-Area Services.

1.4.1 Provider shall provide "in-area" Medically Necessary Covered Services to Members assigned to the Provider.

1.4.2 Provider shall assist with timely discharges of Members receiving "in-area" inpatient services.

1.4.3 Plan shall assist in concurrent review and discharge planning services to Members assigned to Provider who are receiving "in-area" inpatient services.

1.5 Out-of-Area Services.

1.5.1 Plan shall assume payment responsibility for all "out-of-area" Medically Necessary Covered Services provided to Members assigned to Provider when such services cannot be performed "in-area" and Prior Authorization requirements have been met. "Out-of-Area" means all Medically Necessary Covered Services provided outside service area.

1.5.2 Plan and Provider shall oversee concurrent review and discharge planning services to Members assigned to Provider who are receiving "out-of-area" inpatient services.

1.5.3 Plan and Provider shall coordinate and facilitate timely discharges back to Member's service area.

1.5.4 Provider agrees to assist in the nursing home placements utilizing Plan contracted facilities.

1.5.5 Provider and Plan shall arrange for inter-facility transfers of Members back into "in-area" service and Plan shall assume financial responsibility.

1.6 Excluded Services. The Provider is not responsible for providing, and the Plan is not responsible for paying costs for, the Member Services set forth below:

1.6.1 No Legal Obligation. Medical Services for which neither the recipient nor any other person or organization incurs a legal obligation to pay. Such non-covered services may include, but are not limited to:

- ❖ Free chest x-ray provided by voluntary health organization.
- ❖ Free samples of items received at no cost.

1.6.2 Non-Covered Services. Services that are not covered with Participating Plans or Services that AHCCCS does not cover, include, but are not limited to:

- ❖ Services mandated for purposes of meeting non-medical requirements, such as employment physicals and Physician visits required for a license, certificate, or for obtaining third party liability or disability payments.
- ❖ Services provided by or under the direction of naturopaths.
- ❖ Personal comfort items or services.
- ❖ Cosmetic surgery intended solely to improve the physical appearance of a recipient and which does not restore bodily function or correct a deformity.
- ❖ Reconstructive surgical procedures intended to improve function and appearance of any body that has been altered by disease, trauma, congenital or developmental anomalies or previous surgical processes unless the services are Covered Services that are Medically Necessary and Prior Authorized. Clear and precise documentation substantiating Medical Necessity for reconstructive surgery is required for a Covered Service determination.
- ❖ Therapeutic legally induced abortions and abortion counseling unless the pregnancy termination is the result of rape or incest, or in circumstances where the member suffers from a physical disorder, physical injury, or physical illness, including a life endangering physical condition caused by or arising from the pregnancy itself, that would, if certified by a physician, place the member in danger of death unless the pregnancy is terminated and is prior approved by the Plan.
- ❖ Post mastectomy breast reconstruction. An initial prosthesis, including a surgical brassiere, is covered if medically necessary.
- ❖ Penile implants for recipients over 21 years of age.
- ❖ Infertility services, reversal of surgical sterilization, sex change operations.
- ❖ Hysterectomies unless medically necessary.
- ❖ Hearing aids, except as allowed under EPSDT program for recipients under 21.
- ❖ Eye examination and eyeglasses, except as allowed under EPSDT program for recipients under 21. Glasses and contact lenses are not excluded if they are the sole prosthetic devise after cataract extraction.
- ❖ Routine dental care, except as allowed under EPSDT program for recipients under 21.
- ❖ Orthognathic surgery for recipients over 21 years of age.
- ❖ Outpatient Occupational or Speech therapy except as allowed under EPSDT, ALTCS, and KidsCare.

- ❖ Service for items requiring Prior Authorization for which prior authorization has not been obtained or has been denied.
- ❖ Services determined to be experimental or provided primarily for the purpose of research.
- ❖ Artificial or mechanical hearts or xenografts.
- ❖ Heart transplantation and allogeneic and autologous bone marrow transplantation, unless the recipient is categorically eligible.
- ❖ Liver transplantation, unless the recipient is categorically eligible and under age 21.
- ❖ Behavioral health services for non-categorically eligible acute care recipients, except for limited emergency/crisis stabilization services.
- ❖ Behavioral health services for ALTCS recipients ages 21 through 64, except for limited emergency/crisis stabilization services.
- ❖ Services to prison inmates or residents of a tuberculosis or Behavioral Health Treatment institution.
- ❖ Treatment for drug abuse unless authorized in rules.

1.7 Vaccines for Children (VFC) Program. The vaccine portion of childhood immunizations shall be reimbursed through the State of Arizona's VFC Program. It is the responsibility of Provider to submit billings to the VFC Program for reimbursement. The Plan will not reimburse Provider for the administration of the vaccines in excess of the maximum allowable as set by CMS. The Plan will pay ten dollars (\$10.00) for the administration of the vaccine.

1.8 Supplemental Payment Program. Provider has chosen not to participate in the supplemental payment program.

1.9 Physician Incentive Regulations. Notwithstanding any provision in this Agreement to the contrary, Plan and Provider shall comply with all applicable physician incentive plan requirements and conditions set forth in 42 C.F.R. SS417.497, as amended.

1.10 Risk Pool Sharing. Provider has chosen not to participate in risk pool arrangements.

SECTION 2. BILLING AND REPORTING REQUIREMENTS

2.1 General. Regardless of the payment or reimbursement method (capitation or fee schedule), for every Medically Necessary Covered Service for which Provider seeks reimbursement on behalf of itself and all PHPs, Provider agrees to submit a Clean Claim to Plan on a properly executed, current CMS 1500 form, and an itemized statement upon request of Plan, within ninety (90) days from the date of service. Claims initially received more than ninety (90) days for the date of service will be denied. Plan agrees to pay Provider within forty-five (45) days receipt of a Clean Claim.

2.2 Required Claim or Encounter Information. At a minimum, all Claims or Encounters shall provide the information required within the CMS 1500 form and the following information:

- Ø Member's name, sex and date of birth
- Ø Member's AHCCCS Identification Number
- Ø Diagnosis Code (International Classification of Diseases (ICD) – 9 Codes)
- Ø Procedure Code (Current CMS Common Procedure Coding System (HCPCS) Codes including Current Procedural Terminology (CPT))
- Ø Units of service
- Ø Place of service
- Ø Type of service
- Ø Dates of service (must be reported using individual dates of service. Date spans are not acceptable)
- Ø Amount billed (usual and customary)
- Ø COB & subrogation flag (indicate yes/no)
- Ø Plan's Authorization Number
- Ø Provider's name, address and authorized signature

Ø Provider's AHCCCS Identification Number and AHCCCS assigned service locator code

2.2.1 Failure to submit any of the above information and data, failure to respond to a request from Plan for additional information or data, or failure to comply with Plan's Prior Authorization/Notification policy requirements of this Agreement within the described time period may result in delay or denial of payment.

2.2.2 If Plan is subject to penalties or sanctions under its contract with AHCCCS due to failure of Provider to report or submit accurate claim or Encounter information, supported by the medical record, Provider shall either reimburse Plan or Plan shall deduct the amount of the penalty from future payments to Provider, on behalf of Provider or any PHP, at the sole discretion of Plan.

2.2.3 If any Provider's failure to comply with Plan's policies and procedures or this Agreement result in either (1) inappropriate or unauthorized medical expenses, or (2) sanctions to Plan, Plan may deduct such costs from future payments to Provider or demand repayment from Provider.

2.2.4 Encounters and claims are to be mailed to:

University Family Care
PO Box 35699
Phoenix, AZ 85069

University Physicians Care Advantage
PO Box 38549
Phoenix, AZ 85069

2.3 Retrospective Review. Through retrospective review, Plan shall ensure that services rendered were Medically Necessary Covered Services, provided in compliance with AHCCCS Medical Policy Manual (AMPM) guidelines and medical standards of care, and substantiated with documentation supporting the level of services billed as specified by AHCCCS regulations. Plan shall deny any claim not satisfying these criteria. Plan shall conduct retrospective review on both a pre-payment and post-payment basis. Plan may deduct the amount of erroneous payments from future payments to Provider or demand repayment from Provider.

2.4 Claims Processing. Plan's date of receipt of claims is the date the claim was received by Plan as indicated by the date stamp on the claim and the claim reference number. Claims will be considered paid on the date indicated on disbursement checks. Denied claims will be considered adjudicated on the date of their denial. Claims that are denied and are resubmitted will receive new date stamps. Claims that are pending for additional supporting documentation from Provider will receive new date stamps upon receipt of the additional documentation except as provided under Section 2.2 of this Exhibit.

SECTION 3. COORDINATION OF BENEFITS

3.1 Plan is the payor of last resort and Provider shall identify and first bill other third-party carriers or insurers.

3.2 If Member has third-party coverage, including, but not limited to, Part A or Part B Medicare, Provider shall identify and seek such payment before submitting claims to Plan in accordance with the following:

3.2.1 Provider shall include a completed copy of the third-party carrier's explanation of benefits (EOB) or remittance advice (RA) when submitting a claim for a non-capitated service for the balance due under non-duplication of benefits. A claim, plus a completed copy of the third-party carrier's EOB or RA for any balance due, must be initially received by the Plan within sixty (60) days from the third-party carrier's EOB or RA date.

3.2.2 For Members, only the difference between the Medicare allowable charges, as shown on the Explanation of Medicare Benefits (EOMB), and the Medicare reimbursement received, will be eligible for payment by Plan. Plan's payment of coinsurance plus any applicable deductibles will constitute payment in full to Provider.

3.2.3 For Plan's non-Medicare Members, the allowed amount will be based upon the Plan fee schedule, less the paid amount of the other third-party carrier(s); any balance of which will be paid by Plan as non-duplication of benefits.

3.2.4 In the event Provider identifies any third party source of payment or liability, Provider shall immediately notify Plan of such source.

SECTION 4. CLAIMS RESUBMISSION

4.1 Provider may resubmit claims that have been denied or adjudicated by Plan, but they must be received by Plan within one hundred and twenty (120) days from the date of the initial Plan EOB.

4.2 Plan will re-adjudicate claims resubmitted by Provider only if an initial claim has been filed within the described submission deadline.

4.3 Claim submissions shall be designated as such and shall consist of the following:

- Ø Copy of claim;
- Ø Copy of Plan remit;
- Ø Supporting documentation; and
- Ø Written explanation as to reasons for resubmission.

Resubmitted claims are to be addressed and mailed to the Plan Claims Department at the following address:

University Family Care
PO Box 35699
Phoenix, AZ 85069

University Physicians Care Advantage
PO Box 38549
Phoenix, AZ 85069

4.4 A tracer claim may be submitted in follow up to claims that have been determined to be "not received" or "not in the system" by the Plan. Tracer claims must be received within (ninety) 90 days from the date of service and must be marked "tracer" or "second submission". Tracer claims should not be submitted less than twenty-one (21) days from the first submission, allowing for processing of the original claim.

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EXHIBIT 5
AHCCCS MINIMUM SUBCONTRACT PROVISIONS
[The following provisions must be included verbatim in every contract.]

For the sole purpose of this Attachment, the following definitions apply:

“*Subcontract*” means any contract between the Contractor and a third party for the performance of any or all services or requirements specified under the Contractor’s contract with AHCCCS.

“*Subcontractor*” means any third party with a contract with the Contractor for the provision of any or all services or requirements specified under the Contractor’s contract with AHCCCS.

Subcontractors who provide services under the AHCCCS ALTCS and or the Acute Care Program must comply with the following applicable rules and statutes:

- Rules for the ALTCS are found in Arizona Administrative Code (AAC) Title 9, Chapter 28. AHCCCS statutes for long term care are generally found in Arizona Revised Statute (ARS) 36, Chapter 29, Article 2.
- Rules for the Acute Care Program are found in AAC Title 9, Chapter 22. AHCCCS statutes for the Acute Care Program are generally found in ARS 36, Chapter 29, Article 1. Rules for the KidsCare Program are found in AAC Title 9, Chapter 31 and the statutes for KidsCare Program may be found in ARS 36, Chapter 29, Article 4.

All statutes, rules and regulations cited in this attachment are listed for reference purposes only and are not intended to be all inclusive.

1. ASSIGNMENT AND DELEGATION OF RIGHTS AND RESPONSIBILITIES

No payment due the Subcontractor under this subcontract may be assigned without the prior approval of the Contractor. No assignment or delegation of the duties of this subcontract shall be valid unless prior written approval is received from the Contractor. (AAC R2-7-305)

2. AWARDS OF OTHER SUBCONTRACTS

AHCCCS and/or the Contractor may undertake or award other contracts for additional or related work to the work performed by the Subcontractor and the Subcontractor shall fully cooperate with such other contractors, subcontractors or state employees. The Subcontractor shall not commit or permit any act which will interfere with the performance of work by any other contractor, subcontractor or state employee. (AAC R2-7-308)

3. CERTIFICATION OF COMPLIANCE – ANTI-KICKBACK AND LABORATORY TESTING

By signing this subcontract, the Subcontractor certifies that it has not engaged in any violation of the Medicare Anti-Kickback statute (42 USC §§1320a-7b) or the “Stark I” and “Stark II” laws governing related-entity referrals (PL 101-239 and PL 101-432) and compensation there from. If the Subcontractor provides laboratory testing, it certifies that it has complied with 42 CFR §411.361 and has sent to AHCCCS simultaneous copies of the information required by that rule to be sent to the Centers for Medicare and Medicaid Services. (42 USC §§1320a-7b; PL 101-239 and PL 101-432; 42 CFR §411.361)

4. CERTIFICATION OF TRUTHFULNESS OF REPRESENTATION

By signing this subcontract, the Subcontractor certifies that all representations set forth herein are true to the best of its knowledge.

5. CLINICAL LABORATORY IMPROVEMENT AMENDMENTS OF 1988

The Clinical Laboratory Improvement Amendment (CLIA) of 1988 requires laboratories and other facilities that test human specimens to obtain either a CLIA Waiver or CLIA Certificate in order to obtain reimbursement from the Medicare and Medicaid (AHCCCS) programs. In addition, they must meet all the requirements of 42 CFR 493, Subpart A.

To comply with these requirements, AHCCCS requires all clinical laboratories to provide verification of CLIA Licensure or Certificate of Waiver during the provider registration process. Failure to do so shall result in either a termination of an active provider ID number or denial of initial registration. These requirements apply to all clinical laboratories.

Pass-through billing or other similar activities with the intent of avoiding the above requirements are prohibited. The Contractor may not reimburse providers who do not comply with the above requirements (CLIA of 1988; 42 CFR 493, Subpart A).

6. COMPLIANCE WITH AHCCCS RULES RELATING TO AUDIT AND INSPECTION

The Subcontractor shall comply with all applicable AHCCCS Rules and Audit Guide relating to the audit of the Subcontractor's records and the inspection of the Subcontractor's facilities. If the Subcontractor is an inpatient facility, the Subcontractor shall file uniform reports and Title XVIII and Title XIX cost reports with AHCCCS (ARS 41-2548; 45 CFR 74.48 (d)).

7. COMPLIANCE WITH LAWS AND OTHER REQUIREMENTS

The Subcontractor shall comply with all federal, State and local laws, rules, regulations, standards and executive orders governing performance of duties under this subcontract, without limitation to those designated within this subcontract [42 CFR 434.70 and 42 CFR 438.6(l)].

8. CONFIDENTIALITY REQUIREMENT

The Subcontractor shall safeguard confidential information in accordance with federal and state laws and regulations, including but not limited to, 42 CFR Part 431, Subpart F, ARS §36-107, 36-2903, 41-1959 and 46-135, AHCCCS Rules, the Health Insurance Portability and Accountability Act (Public Law 107-191, 110 Statutes 1936), and 45 CFR Parts 160 and 164.

9. CONFLICT IN INTERPRETATION OF PROVISIONS

In the event of any conflict in interpretation between provisions of this subcontract and the AHCCCS Minimum Subcontract Provisions, the latter shall take precedence.

10. CONTRACT CLAIMS AND DISPUTES

Contract claims and disputes arising under A.R.S Title 36, Chapter 29 shall be adjudicated in accordance with AHCCCS Rules and A.R.S. §36-2903.01.

11. ENCOUNTER DATA REQUIREMENT

If the Subcontractor does not bill the Contractor (e.g., Subcontractor is capitated), the Subcontractor shall submit encounter data to the Contractor in a form acceptable to AHCCCS.

12. EVALUATION OF QUALITY, APPROPRIATENESS, OR TIMELINESS OF SERVICES

AHCCCS or the U.S. Department of Health and Human Services may evaluate, through inspection or other means, the quality, appropriateness or timeliness of services performed under this subcontract.

13. FRAUD AND ABUSE

If the Subcontractor discovers, or is made aware, that an incident of suspected fraud or abuse has occurred, the Subcontractor shall report the incident to the prime Contractor as well as to AHCCCS, Office of Program Integrity. All incidents of potential fraud should be reported to AHCCCS, Office of the Director, Office of Program Integrity.

14. GENERAL INDEMNIFICATION

The parties to this contract agree that AHCCCS shall be indemnified and held harmless by the Contractor and Subcontractor for the vicarious liability of AHCCCS as a result of entering into this contract. However, the parties further agree that AHCCCS shall be responsible for its own negligence. Each party to this contract is responsible for its own negligence.

15. INSURANCE

[This provision applies only if the Subcontractor provides services directly to AHCCCS members]

The Subcontractor shall maintain for the duration of this subcontract a policy or policies of professional liability insurance, comprehensive general liability insurance and automobile liability insurance in amounts that meet Contractor's requirements.

The Subcontractor agrees that any insurance protection required by this subcontract, or otherwise obtained by the Subcontractor, shall not limit the responsibility of Subcontractor to indemnify, keep and save harmless and defend the State and AHCCCS, their agents, officers and employees as provided herein. Furthermore, the Subcontractor shall be fully responsible for all tax obligations, Worker's Compensation Insurance, and all other applicable insurance coverage, for itself and its employees, and AHCCCS shall have no responsibility or liability for any such taxes or insurance coverage. (45 CFR Part 74) The requirement for Worker's Compensation Insurance does not apply when a Subcontractor is exempt under ARS 23-901, and when such Subcontractor executes the appropriate waiver (Sole Proprietor/Independent Contractor) form.

16. LIMITATIONS ON BILLING AND COLLECTION PRACTICES

Except as provided in federal and state law and regulations, the Subcontractor shall not bill, or attempt to collect payment from a person who was AHCCCS eligible at the time the covered service(s) were rendered, or from the financially responsible relative or representative for covered services that were paid or could have been paid by the System.

17. MAINTENANCE OF REQUIREMENTS TO DO BUSINESS AND PROVIDE SERVICES

The Subcontractor shall be registered with AHCCCS and shall obtain and maintain all licenses, permits and authority necessary to do business and render service under this subcontract and, where applicable, shall comply with all laws regarding safety, unemployment insurance, disability insurance and worker's compensation.

18. NON-DISCRIMINATION REQUIREMENTS

The Subcontractor shall comply with State Executive Order No. 99-4, which mandates that all persons, regardless of race, color, religion, gender, national origin or political affiliation, shall have equal access to employment opportunities, and all other applicable Federal and state laws, rules and regulations, including the Americans with Disabilities Act and Title VI. The Subcontractor shall take positive action to ensure that applicants for employment, employees, and persons to whom it provides service are not discriminated against due to race, creed, color, religion, sex, national origin or disability. (Federal regulations, State Executive order # 99-4)

19. PRIOR AUTHORIZATION AND UTILIZATION MANAGEMENT

The Contractor and Subcontractor shall develop, maintain and use a system for Prior Authorization and Utilization Review that is consistent with AHCCCS Rules and the Contractor's policies.

20. RECORDS RETENTION

The Subcontractor shall maintain books and records relating to covered services and expenditures including reports to AHCCCS and working papers used in the preparation of reports to AHCCCS. The Subcontractor shall comply with all specifications for record keeping established by AHCCCS. All books and records shall be maintained to the extent and in such detail as required by AHCCCS Rules and policies. Records shall include but not be limited to financial statements, records relating to the quality of care, medical records, dental records, prescription files and other records specified by AHCCCS.

The Subcontractor agrees to make available at its office at all reasonable times during the term of this contract and the period set forth in the following paragraphs, any of its records for inspection, audit or reproduction by any authorized representative of AHCCCS, State or Federal government.

The Subcontractor shall preserve and make available all records for a period of five years from the date of final payment under this contract unless a longer period of time is required by law.

If this contract is completely or partially terminated, the records relating to the work terminated shall be preserved and made available for a period of five years from the date of any such termination. Records which relate to grievances, disputes, litigation or the settlement of claims arising out of the performance of this contract, or costs and expenses of this contract to which exception has been taken by AHCCCS, shall be retained by the Subcontractor for a period of five years after the date of final disposition or resolution thereof unless a longer period of time is required by law. (45 CFR 74.53; 42 CFR 431.17; ARS 41-2548)

21. SEVERABILITY

If any provision of these standard subcontract terms and conditions is held invalid or unenforceable, the remaining provisions shall continue valid and enforceable to the full extent permitted by law.

22. SUBJECTION OF SUBCONTRACT

The terms of this subcontract shall be subject to the applicable material terms and conditions of the contract existing between the Contractor and AHCCCS for the provision of covered services.

23. TERMINATION OF SUBCONTRACT

AHCCCS may, by written notice to the Subcontractor, terminate this subcontract if it is found, after notice and hearing by the State, that gratuities in the form of entertainment, gifts, or otherwise were offered or given by the Subcontractor, or any agent or representative of the Subcontractor, to any officer or employee of the State with a view towards securing a contract or securing favorable treatment with respect to the awarding, amending or the making of any determinations with respect to the performance of the Subcontractor; provided, that the existence of the facts upon which the state makes such findings shall be in issue and may be reviewed in any competent court. If the subcontract is terminated under this section, unless the Contractor is a governmental agency, instrumentality or subdivision thereof, AHCCCS shall be entitled to a penalty, in addition to any other damages to which it may be entitled by law, and to exemplary damages in the amount of three times the cost incurred by the Subcontractor in providing any such gratuities to any such officer or employee. (AAC R2-5-501; ARS 41-2616 C.; 42 CFR 434.6, a. (6))

24. VOIDABILITY OF SUBCONTRACT

This subcontract is voidable and subject to immediate termination by AHCCCS upon the Subcontractor becoming insolvent or filing proceedings in bankruptcy or reorganization under the United States Code, or upon assignment or delegation of the subcontract without AHCCCS's prior written approval.

25. WARRANTY OF SERVICES

The Subcontractor, by execution of this subcontract, warrants that it has the ability, authority, skill, expertise and capacity to perform the services specified in this contract.

26. OFF-SHORE PERFORMANCE OF WORK PROHIBITED

Due to security and identity protection concerns, direct services under this contract shall be performed within the borders of the United States. Any services that are described in the specifications or scope of work that directly serve the State of Arizona or its clients and may involve access to secure or sensitive data or personal client data or development or modification of software for the State shall be performed within the borders of the United States. Unless specifically stated otherwise in specifications, this definition does not apply to indirect or "overhead" services, redundant back-up services or services that are incidental to the performance of the contract. This provision applies to work performed by subcontractors at all tiers.

27. FEDERAL IMMIGRATION AND NATIONALITY ACT

The Subcontractor shall comply with all federal, state and local immigration laws and regulations relating to the immigration status of their employees during the term of the contract. Further, the Subcontractor shall flow down this requirement to all subcontractors utilized during the term of the contract. The State shall retain the right to perform random audits of Contractor and subcontractor records or to inspect papers of any employee thereof to ensure compliance. Should the State determine that the Contractor and/or any subcontractors be found noncompliant, the State may pursue all remedies allowed by law, including, but not limited to; suspension of work, termination of the contract for default and suspension and/or debarment of the Contractor.

EXHIBIT 6
University Physicians Care Advantage –Compensation
For
Gila County Health Department

INTERPRETATION

To the extent there is a conflict between the terms of this Exhibit and any terms of the Agreement, the terms of this Exhibit shall govern as they apply to services furnished under a Medicare Advantage Program.

Provider and Plan intend that the terms of the Agreement, as they relate to the provision of services under the Medicare Advantage Program, shall be interpreted in a manner consistent with applicable requirements under Medicare law.

1.0 MEDICARE ADVANTAGE DELEGATION

1.1 Provider acknowledges that a Medicare Advantage Organization has delegated to Plan certain responsibility under its Medicare Advantage contract to provide Medicare Covered Services to its Medicare Advantage Members. In turn, Plan has delegated to Provider its responsibility to provide those Medicare Covered Services within the scope of Providers' licensure or certification and expertise to Medicare Advantage Members. Provider agrees that Plan and the Medicare Advantage Organization may only delegate such responsibilities in a manner consistent with the standards set forth under 42 CFR §422.504(i)(3) and (4). Provider agrees that Plan or the Medicare Advantage Organization may revoke this delegation and thereby terminate this Exhibit if Provider does not perform satisfactorily and if any of Provider's reporting and disclosure obligations are not fully met in a timely manner.

1.2 Provider acknowledges that the Medicare Advantage Organization and Plan shall oversee and monitor Provider's performance on an ongoing basis. Provider further acknowledges that the Medicare Advantage Organization is accountable to CMS for the functions and responsibilities described in the Medicare Advantage contract and regulatory standards.

1.3 Provider agrees to comply, and to require any and all of its subcontractors and employees to comply, with all applicable Medicare laws, regulations, and CMS instructions. Further, Provider agrees that any services provided by Provider or its subcontractors to Medicare Advantage Members will be consistent with, and will comply with, the Medicare Advantage Organization's contractual obligations.

1.4 Provider shall credential Providers on behalf of the Medicare Advantage Organization. Provider agrees to comply with all aspects of the Medicare Advantage Organization's credentialing and recredentialing policies and procedures. Provider agrees that the credentialing process will be reviewed and approved by Medicare Advantage Organization and that Medicare Advantage Organization will audit the credentialing process on an on going basis.

2.0 PLAN RESPONSIBILITIES

2.1 Plan will retain the same responsibilities to the Provider as agreed upon in the Agreement to the extent they do not conflict with Medicare Advantage law and policy.

3.0 PROVIDER RESPONSIBILITIES

3.1 Provider will retain the same responsibilities as agreed upon in the Agreement to the extent they do not conflict with Medicare Advantage law and policy.

3.2 Provider acknowledges that to be eligible to enroll in a Medicare Advantage, Medicare beneficiaries must also be eligible for Medicaid coverage. When services are covered under both the Medicare Advantage and Medicaid programs, both the Medicare Advantage and Medicaid policies and procedures shall apply.

3.3 Provider agrees to cooperate with Plan by providing all information necessary for the Medicare Advantage Organization to meet its reporting obligations under 42 CFR §§422.516 and §§ 422.310, including, but not limited to, providing data necessary to characterize the context and purpose of each service furnished to a Medicare Advantage Member.

3.4 Provider agrees that, notwithstanding the terms of the Agreement, Medicare Advantage Members shall have direct access to women's health specialists within the network for women's routine and preventive health care services that are Medicare Covered Services. In addition, Members shall have direct access to screening mammography and influenza vaccines that are Medicare Covered Services and are furnished by a Participating Provider.

3.5 Provider represents that it has the authority to bind all Providers to comply with the terms of this Exhibit.

3.6 Provider agrees that the Medicare Advantage Organization retains the right to approve, suspend or termination any arrangement between Provider and a Provider or its subcontractors to provide services to Medicare Advantage Members under the terms of this Exhibit.

4.0 COMPENSATION AND PROMPT PAYMENT TO PARTICIPATING PROVIDERS

4.1 Plan shall pay Provider one hundred percent (100%) of current CMS fee schedule for Covered Services furnished to Medicare Advantage Members on a fee-for-service basis.

4.2 Claims are to be mailed to:
University Physicians Care Advantage
PO Box 35699
Phoenix, AZ 85069

4.3 Plan shall make payment to Provider within the prompt payment time frames set forth in the Compensation Exhibit of the Agreement.

4.4 Provider agrees that in no event, including, but not limited to, non-payment by Plan or the Medicare Advantage Organization, insolvency of Plan or the Medicare Advantage Organization or breach of the Agreement, shall the Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Medicare Advantage Member or persons acting on their behalf other than Plan for services provided pursuant to the Agreement and this Exhibit. This provision does not prohibit the collection of coinsurance or copayments on Plan's or the Medicare Advantage Organization's behalf made in accordance with the terms of the Medicare Advantage Member's evidence of coverage.

Provider agrees that, in the event of Plan's or the Medicare Advantage Organization's insolvency or other cessation of operations, services to Medicare Advantage Members will continue through the period for which payment has been paid to the Medicare Advantage Organization, and services to Medicare Advantage Members confined in an inpatient facility on the date of insolvency or other cessation of operations will continue until their discharge. Provider further agrees that (i) these hold harmless and continuation of benefits provisions shall survive the termination of the Agreement and this Exhibit regardless of the cause giving rise to the termination and shall be construed to be for the benefit of Medicare Advantage Members; and, that (ii) these provisions supersede any oral or written contrary agreement now existing or hereafter entered into between Plan, a subcontractor or Provider and a Medicare Advantage Member or persons acting on their behalf that relates to liability for payment for, or continuation of, Covered Services provided under the terms and conditions of these clauses.

5.0 TERMS AND TERMINATION

5.1 This Exhibit shall remain in effect subject to the Term and Termination provisions of the Agreement.

6.0 RECORDS MAINTENANCE, AVAILABILITY, INSPECTION, AND AUDIT

6.1 Provider agrees to maintain medical, financial and administrative records related to Covered Services rendered by Provider under the Agreement and this Exhibit in an accurate and timely manner. Provider agrees to abide by all applicable Federal and State laws regarding confidentiality and disclosure for medical records, other health information, and Member information, including, but not limited to, Health Insurance Portability and Accountability Act of 1996, and all rules and regulations promulgated there under. In addition, Provider agrees to abide by the confidentiality requirements established by the Medicare Advantage Organization and Plan and the Medicare Advantage Program as set forth at 42 CFR §422.118.

6.2 Provider agrees to maintain records, documents and any other information relating to Medicare Advantage Members and this Exhibit for ten (10) years or such longer period as required by law. Provider acknowledges that United States Department of Health and Human Services (HHS) may evaluate the quality, appropriateness and timeliness of services furnished to Medicare Advantage Members; Provider's and Plan's facilities; and any enrollment and disenrollment records. Provider further acknowledges that HHS, the Comptroller General, or their designees, have the right to inspect any books, contracts, medical records, patient care documentation, and other records of Provider, or its subcontractors or transferees, involving transactions related to the Medicare Advantage Organization's Medicare Advantage contract through ten (10) years from the final date of the contract period or from the date of the completion of any audit, or for such longer period provided for in 42 CFR §422.504(e)(4).

6.3 This Section shall survive the termination of the Agreement and this Exhibit for services rendered while the Agreement and this Exhibit were in effect.