CITY OF WEST DES MOINES
CITY COUNCIL MEETING COMMUNICATION

DATE: November 4, 2019

ITEM: **Resolution** - Approving the Participating Provider Agreement between the City of West Des Moines and Iowa Total Care, Inc.

FINANCIAL IMPACT: This action results in a positive fiscal impact.

BACKGROUND: The City of West Des Moines Emergency Medical Services (EMS) provides ambulance services for individuals with Medicaid insurance. This Participating Provider Agreement is between the City of West Des Moines and Iowa Total Care a wholly owned subsidiary of Centene, in partnership with the Iowa Department of Human Services and covers non-emergent services.

OUTSTANDING ISSUES (if any): None

RECOMMENDATION: That Council approve the Resolution to authorize the Mayor to execute the Participating Provider Agreement between the City of West Des Moines and Total Care, Inc.

Lead Staff Member: **Chief Craig Leu, EMS**

STAFF REVIEWS

Department Director	Richard Scieszinski, City Attorney
Appropriations/Finance	Tim Stiles, Finance Director
Legal	Richard Scieszinski, City Attorney
Agenda Acceptance	

PUBLICATION(S) (if applicable)

Published In	na
Dates(s) Published	na

SUBCOMMITTEE REVIEW (if applicable)

Committee			
Date Reviewed			
Recommendations	Yes	No	NA

RESOLUTION NO._____

RESOLUTION APPROVING PARTICIPATING PROVIDER AGREEMENT

WHEREAS, the City of West Des Moines Emergency Medical Services (EMS) provides ambulance services; and

WHEREEAS, Iowa Total Care, Inc is a wholly owned subsidiary of Centene, in partnership with the Iowa Department of Human Services; and

WHEREAS, approval of the Participating Provider Agreement will maximize reimbursement rates for Medicaid services; and

WHEREAS, approval of the Participating Provider Agreement between the City of West Des Moines and Iowa Total Care, Inc. is in the best interest of the City of West Des Moines

BE IT RESOLVED BY THE CITY COUNCIL OF THE CITY OF WEST DES MOINES, IOWA, that:

1. The Participating Provider Agreement between the City of West Des Moines and Iowa Total Care, Inc. is hereby approved.
2. The Mayor is authorized to sign the Participating Provider Agreement and the City Clerk is directed to attest to the Mayor's signature.

PASSED AND APPROVED this 4th day of November, 2019.

_____
Steven K. Gaer, Mayor

ATTEST:

_____
Ryan T. Jacobson
City Clerk

PARTICIPATING PROVIDER AGREEMENT

This Participating Provider Agreement (together with all Attachments and amendments, this "Agreement") is made and entered by and between City of West Des Moines ("Provider") and Iowa Total Care, Inc. ("Health Plan ") (each a "Party" and collectively the "Parties"). This Agreement is effective as of the date designated by Health Plan on the signature page of this Agreement ("Effective Date").

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

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

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

ARTICLE I - DEFINITIONS

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

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

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

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

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

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

1.6. Intentionally omitted.

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

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

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

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

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

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

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

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

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

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

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

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

ARTICLE II – PRODUCTS AND SERVICES

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

obligations imposed on Provider under this Agreement (including each Attachment), and the Provider Manual.

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

2.2.1. Intentionally omitted.

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

2.2.3. Provider shall provide Health Plan, from time to time or on a periodic basis as reasonably requested by Health Plan, with a complete and accurate list containing the names, office telephone numbers, addresses, tax identification numbers, hospital affiliations, specialties and board status (if applicable), State license number, and National Provider Identifier and such other information as mutually agreed upon by the Parties, and shall provide Health Plan with a list of modifications to such list at least thirty (30) days prior to the effective date of such changes, when possible.

2.2.4. Intentionally omitted.

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

2.3. Covered Services. Provider shall provide Covered Services described or referenced in the applicable Product Attachment(s) to Covered Persons in those Products in which Provider is a Participating Provider, in accordance with this Agreement. Provider shall provide Covered Services to Covered Persons with the same degree of care and skill as customarily provided to patients who are not Covered Persons, within the scope of Provider's license and in accordance with generally accepted standards of Provider's practice and business and in accordance with the provisions of this Agreement, the Provider Manual, and Regulatory Requirements.

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

2.5. Credentialing Criteria. Provider shall use reasonable efforts to complete Company's and/or Payor's credentialing and/or recredentialing process as required by Company's and/or Payor's credentialing Policies, and shall use reasonable efforts during the term of this Agreement to meet Company's and/or Payor's credentialing criteria. Provider represents, warrants and agrees: (a) that it is currently, and for the duration of this Agreement shall remain: (i) in compliance with all applicable Regulatory Requirements, including licensing laws; (ii) if applicable, accredited by The Joint Commission or the American Osteopathic Association; and (iii) a Medicare participating provider under the federal Medicare program and a Medicaid participating provider under applicable federal and State laws; and (b) that Provider will perform its duties in accordance with all Regulatory Requirements, as well as applicable national, State and local standards of professional ethics and practice. Provider shall not provide Covered Services to Covered Persons or identify itself as a Participating Provider unless and until Provider has been notified, in writing, by Company that Provider has successfully completed Company's credentialing process.

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

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

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

Provider from disclosing to any Covered Person any information that Provider deems appropriate regarding health care quality, medical treatment decisions or alternatives.

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

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

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

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

2.13. Use of Name. Provider hereby authorizes each Company or Payor to use their respective names, telephone numbers, addresses, specialties, certifications, hospital affiliations (if any), and other descriptive characteristics of their facilities, practices and services for the purpose of identifying the Providers as "Participating Providers" in the applicable Products. Provider may only use the name of the applicable Company or Payor for purposes of identifying the Products in which they participate, and may not use the registered trademark or service mark of Company or Payor without prior written consent.

2.14 Compliance with Regulatory Requirements. Provider and Company agree to carry out their respective obligations under this Agreement and the Provider Manual in accordance with all applicable Regulatory Requirements, including, but not limited to, the requirements of the Health Insurance Portability and Accountability Act, as amended, and any regulations promulgated thereunder.

2.15 Program Integrity Required Disclosures. Provider agrees to furnish to Health Plan complete and accurate

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

ARTICLE III – CLAIMS SUBMISSION, PROCESSING, AND COMPENSATION

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

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

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

3.4. Hold Harmless. Provider agrees that in no event, including but not limited to non-payment by a Payor, a Payor's insolvency, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Covered Person or person acting on the Covered Person's behalf, other than Payor, for Covered Services provided under this Agreement. This provision shall not prohibit collection of any applicable copayments, cost-sharing or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement. This provision survives termination or expiration of this Agreement for any reason, will be construed for the benefit of Covered Persons, and supersedes any oral or written agreement entered into between Provider and a Covered Person.

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

ARTICLE IV – RECORDS AND INSPECTIONS

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

4.2. Access. Provider shall provide reasonable access to their respective books and records to each of the following, including any delegate or duly authorized agent thereof, subject to applicable Regulatory Requirements: (i) Company and Payor, during regular business hours and upon reasonable prior notice; (ii) appropriate State and federal authorities, to the extent such access is necessary to comply with Regulatory Requirements; and (iii) accreditation organizations. Provider shall provide copies of such records to any of the foregoing that may make such request. Provider also shall use reasonable efforts to obtain any authorization or consent that may be required from a Covered Person in order to release medical records and information to Company or Payor or any of their delegates. Provider shall use reasonable efforts to cooperate in and allow reasonable on-site inspections of its facilities and records by Company, Payor, their delegates, authorized government officials, and accreditation organizations. Provider shall use reasonable efforts upon reasonable notice to compile information necessary for the expeditious completion of such on-site inspection in a timely manner.

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

ARTICLE V – INSURANCE AND INDEMNIFICATION

5.1. Insurance. During the term of this Agreement and for any applicable continuation period as set forth in Section 7.3 of this Agreement, Provider shall maintain policies of general and professional liability insurance and other insurance necessary to insure Provider and such Contracted Provider, respectively; their respective employees; and any other person providing services hereunder on behalf of Provider or such Contracted Provider, as applicable, against any claim(s) of personal injuries or death alleged to have been caused or caused by their performance under this Agreement. Such insurance shall include, but not be limited to, any "tail" or prior acts coverage necessary to avoid any gap in coverage. Insurance shall be through a licensed carrier acceptable to Health Plan, and in a minimum amount of one million dollars ($1,000,000) per occurrence, and three million dollars ($3,000,000) in the aggregate unless a lesser amount is accepted by Health Plan or where State law mandates otherwise. Provider will provide Health Plan with at least fifteen (15) days prior written notice of cancellation, non-renewal, lapse, or adverse material modification of such coverage. Upon Health Plan's request, Provider and each Contracted Provider will furnish Health Plan with evidence of such insurance.

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

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

ARTICLE VI – DISPUTE RESOLUTION

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

ARTICLE VII – TERM AND TERMINATION

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

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

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

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

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

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

7.2.5. Credentialing. The status of Provider as a Participating Provider in one or more Products may be terminated immediately by Health Plan giving written notice thereof to Provider if Provider fails to adhere to Company's or Payor's credentialing criteria, including, but not limited to, if the Contracted Provider (i) loses, relinquishes, or has materially affected its license to provide Covered Services in the State, (ii) fails to comply with the insurance requirements set forth in this Agreement; or (iii) is convicted of a criminal offense related to involvement in any state or federal health care program or has been terminated, suspended, barred, voluntarily withdrawn as part of a settlement agreement, or otherwise excluded from any state or federal health care program.

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

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

ARTICLE VIII - MISCELLANEOUS

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

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

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

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

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

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

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

8.7.1. Health Plan may amend this Agreement by giving Provider thirty (30) day written notice of the amendment to the extent such amendment is necessary for Health Plan to comply with any Regulatory Requirements. Any such amendment will be deemed accepted by Provider upon the giving of such notice.

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

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

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

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

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

To Health Plan at:	To Provider at:
Attn: President	Attn: Chief Craig Leu
Iowa Total Care, Inc.	City of West Des Moines
1080 Jordan Creek Pkwy, Suite 100 South	P.O. Box 65320
West Des Moines, IA 50266	West Des Moines, IA 50265
	cleu@wdm.iowa.gov

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

8.12. Force Majeure. Neither Party shall be liable or deemed to be in default for any delay or failure to perform any act under this Agreement resulting, directly or indirectly, from acts of God, civil or military authority, acts of public enemy, war, accidents, fires, explosions, earthquake, flood, strikes or other work stoppages by either Party's employees, or any other similar cause beyond the reasonable control of such Party.

8.13. Proprietary Information. Health Plan understands Provider is a government entity and subject to Iowa Code Chapters 21 and 22.

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

* * * * *

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

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

HEALTH PLAN:	**PROVIDER:**
Iowa Total Care, Inc.	City of West Des Moines (Legibly Print Name of Provider)
Authorized Signature:	Authorized Signature:
Print Name:	Print Name:
Title:	Title:
Signature Date:	Signature Date:
ECM #: 416439	Tax Identification Number: 42-6005359
	State Medicaid Number:
To be completed by Health Plan only: Effective Date:	National Provider Identifier: Medicare Number:

PARTICIPATING PROVIDER AGREEMENT

SCHEDULE A
INENTIONALLY OMITTED
PARTICIPATING PROVIDER AGREEMENT

SCHEDULE B
PRODUCT PARTICIPATION

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

List of Product Attachments:

Attachment A: Medicaid
Attachment B: [Reserved]
Attachment C: Commercial-Exchange

PARTICIPATING PROVIDER AGREEMENT

SCHEDULE C
CONTRACTED PROVIDERS

ENTITY/GROUP/CLINIC/FACILITY NAME	TAX ID #	NPI #

NOTE: This Schedule is intended to capture all groups, clinics and facilities participating under the Agreement (i.e., are Contracted Providers under this Agreement) as of the Effective Date.

Attachment A: Medicaid

MEDICAID PRODUCT ATTACHMENT

This PRODUCT ATTACHMENT ("***Attachment***") is made and entered between Iowa Total Care, Inc. (***"Health Plan"***) and City of West Des Moines ("***Provider***").

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

WHEREAS, pursuant to the provisions of the Agreement, this Attachment is identified on the signature page of the Agreement and, as such, Provider will be designated and participate as "***Participating Provider***" in the Product described in this Attachment; and

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

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

1. Defined Terms. For purposes of the Medicaid Product (as herein defined), the following terms (and the plural thereof, when appropriate) have the meaning set forth below. All capitalized terms not specifically defined in this Attachment will have the meaning given to such terms in the Agreement.

1.1 "***Agency***" means the Iowa Department of Human Services.

1.2 "***Clean Claim***" means a claim that has no defect or impropriety (including any lack of required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment of the claim. 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.

1.3 "***Medicaid Product***" (sometimes this "***Product***") refers to those programs and health benefit arrangements offered by Company pursuant to contract(s) with one or more state Medicaid agency(ies), or any successors thereto, to provide specified services and goods to covered beneficiaries under state Medicaid-funded programs and to meet certain performance standards while doing so (each a "***State Contract***"). The Medicaid Product does not apply to Coverage Agreements that are specifically covered by another Product Attachment to the Agreement.

1.4 "***Medically Necessary***" or "***Medical Necessity***" means those Covered Services that are, under the terms and conditions of the State Contract, determined through Health Plan or Payor utilization management to be:

A. appropriate and necessary for the symptoms, diagnosis or treatment of the condition of the Covered Person;

B. provided for the diagnosis or direct care and treatment of the condition of Covered Person enabling the Covered Person to make reasonable progress in treatment;

C. within standards of professional practice and given at the appropriate time and in the appropriate setting;

D. not primarily for the convenience of the Covered Person, the Covered Person's

physician or other provider; and

E. the most appropriate level of Covered Services, which can safely be provided.

1.5 "***State***" means Iowa.

1.6 "***Subcontractor***" means a third party who contracts with the Health Plan or another subcontractor to perform a portion of the duties in the Scope of Work under the State Contract. This does not include providers who solely provide medical services to Covered Persons pursuant to a provider agreement.

2. Product Participation.

2.1 Medicaid and/or CHIP Product. This Product Attachment constitutes the "***Medicaid Product Attachment***" and is incorporated into the Agreement between Provider and Health Plan. It supplements the Agreement by setting forth specific terms and conditions that apply to the Medicaid Product with respect to which a Participating Provider has agreed to participate, and with which a Participating Provider must substantially comply with in order to maintain such participation. This Attachment applies only to the provision of health care services, supplies or accommodations (including Covered Services) to Covered Persons enrolled in or covered by a Medicaid Product.

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

2.3 Attachment. This Attachment constitutes the Product Attachment and Compensation Schedule for the Medicaid Product.

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

3. Term. This Attachment will become effective as of the Effective Date, and will be coterminous with the Agreement unless a party or a Contracted Provider terminates the participation of the Contracted Provider in this Product in accordance with the applicable provisions of the Agreement or this Attachment.

4. State Mandated Program Requirements. Schedule A to this Attachment, which is incorporated herein by this reference, sets forth the provisions that are required by the applicable State Contract with respect to the Medicaid Product. Any additional requirements that may apply to the Coverage Agreements or Covered Persons enrolled in or covered by this Product may be set forth in the Provider Manual or another Attachment and are incorporated herein by this reference.

5. Other Terms and Conditions. Except as modified or supplemented by this Attachment, the compensation hereunder for the provision of Covered Services by Contracted Providers to Covered Persons enrolled in or covered by the Medicaid Product is subject to all of the other provisions in the Agreement (including the Provider Manual) that affect or relate to compensation for Covered Services provided to Covered Persons.

Attachment A: Medicaid

SCHEDULE A
GOVERNMENTAL CONTRACT REQUIREMENTS

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

1. Definitions. As used in this Schedule A to Attachment A, the following terms shall be defined as set forth below.

1.1. "***Agency***" means the Iowa Department of Human Services.

1.2. "***Clean Claim***" means one in which all information required for processing is present.

1.3. "***Covered Services***" means the services provided under Medicaid, and provided, or arranged to be provided by Health Plan to Covered Persons pursuant to the State Contract.

1.4. "***Department***" means the Iowa Department of Human Services or its designee.

1.5. "***DHS***" means the Iowa Department of Human Services.

1.6. "***HCBS***" means home and community based services.

1.7. "***IDPH***" means the Iowa Department of Public Health.

1.8. "***LTSS***" means long term services and supports.

1.9. "***PCP***" means a primary care physician or other licensed health practitioners practicing in accordance with State law who is responsible for providing preventive and primary health care to patients; for initiating referrals for specialist care; and for maintaining the continuity of patient care.

1.10. "***State***" means the State of Iowa.

2. Federal and State Laws and Regulations. Provider shall comply with all applicable federal and State Regulatory Requirements pertinent to Covered Person confidentiality and rights, and shall ensure that its staff and subcontractors, including but not limited to Contracted Providers, take those rights into account when furnishing services to Covered Persons.

3. Ownership Disclosures. Provider shall make full disclosure of ownership, management and control information as required by 42 CFR 455.100 through 455.106 to Health Plan, within such timeframes as necessary to allow Health Plan to comply with the disclosure obligations set forth in the State Contract, including but not limited to providing such information to Health Plan within twenty-five (25) days after any change in ownership.

4. EPSDT Services. If Provider is a PCP, Provider, as applicable, must provide early and periodic screening, diagnosis and treatment (EPSDT) services to all Covered Persons under twenty-one (21) years of age in accordance with the applicable Regulatory Requirements. Provider, as applicable, shall comply with Health Plan's strategies to ensure the completion of health screens and preventive visits in accordance with the Care for Kids (EPSDT) periodicity schedule. Screening exams consist of a health history, developmental history, complete physical exam, vision screening, hearing test, appropriate laboratory tests, immunizations, nutrition screen, health education including anticipatory guidance, oral health assessment, other tests as needed and referrals for treatment. All records requested by State or federal personnel, including medical and peer review records, must be available for inspection by State or federal personnel or their representatives. Provider shall make available to Health Plan those data

necessary for Health Plan to record health screenings and examination-related activities. Provider acknowledges that Health Plan is required to periodically report such findings to the State.

5. Subcontractor Insurance. If Participating Provider is a Subcontractor, it, he or she shall maintain in full force and effect, throughout the term of the Agreement, the types of insurance in the minimum amounts specified in the State Contract with insurance companies licensed by the State, including insurance against all general liabilities, product liability, personal injury, property damage, and (where applicable) professional liability.

6. Subcontracts. If Provider is a Subcontractor, this Section will apply.

6.1 Delegation. If any of Health Plan's activities or obligations under the State Contract are delegated to Provider:

(a) the delegated activities or obligations, and related reporting responsibilities, are specified in the Agreement;

(b) Provider shall perform the delegated activities and reporting responsibilities specified in compliance with the Health Plan's obligations under the State Contract; and

(c) the Agreement either provides for revocation of the delegation of activities or obligations, or specifies other remedies in instances where the Agency or the Health Plan determines that the Provider has not performed satisfactorily.

6.2 Compliance with Medicaid Law. Each Participating Provider agrees to comply with all applicable Medicaid laws, regulations, including applicable sub-regulatory guidance and contract provisions.

6.3 Audits and Access to Records. Each Participating Provider agrees that the Agency, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the Participating Provider, or of the Participating Provider's contractors, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Health Plan's State Contract with the Agency. Each Participating Provider will make available, for purposes of an audit, evaluation, or inspection under this paragraph, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid members. The right to audit under this paragraph will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. If the Agency, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the Agency, CMS, or the HHS Inspector General may inspect, evaluate, and audit the Participating Provider at any time.

7. Protecting Members Against Liability for Payment. In compliance with 42 C.F.R. § 438.106, each Participating Provider agrees that Covered Persons will not be held liable for any of the following: (a) the Health Plan's or Payor's debts, in the event of insolvency; (b) Covered Services provided to the Covered Person, for which (i) the Agency does not pay the Health Plan, or (ii) the Agency, or the Health Plan does not pay the individual or Participating Provider that furnished the services under a contractual, referral, or other arrangement; or (c) payments for Covered Services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the Covered Person would owe if the Health Plan covered the services directly.

8. Maintenance of Records. In accordance with 42 C.F.R. §438.3(u), if Provider is a Subcontractor, Provider shall retain, and require its subcontractors to retain, as applicable, the following information: member grievance and appeal records in 42 C.F.R. § 438.416, base data in 42 C.F.R. § 438.5(c), MLR reports in 42 C.F.R. § 438.8(k), and the data, information, and documentation specified in 42 C.F.R. §§ 438.604, 438.606, 438.608, and 438.610 for a period of no less than 10 years.

9. Response to Record Requests. In accordance with 42 C.F.R. 438.3(h), the Agency, CMS, the Office of the Inspector General, the Comptroller General, and their designees may, at any time, inspect and audit any records or

documents of the Health Plan, or its subcontractors (including Participating Provider), and may, at any time, inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted. The right to audit under this section exists for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. Participating Provider shall furnish duly authorized and identified agents or representatives of the State and federal governments with such information as they may request regarding payments claimed for Medicaid services.

10. Prohibited Status. Each Participating Provider warrants and represents that it, he or she is not:

10.1 an entity that could be excluded under section 1128(b)(8) of the Social Security Act as being controlled by a sanctioned individual;

10.2 an entity that has a substantial contractual relationship as defined in 42 C.F.R. § 431.55(h)(3), either directly or indirectly, with an individual convicted of certain crimes as described in section 1128(b)(8)(B) of the Social Security Act or an individual described in 42 C.F.R. § 438.610(a) and (b);

10.3 an entity that employs or contracts, directly or indirectly, for the furnishing of health care, utilization review, medical social work, or administrative services, with one of the following: (i) any individual or entity described in 42 C.F.R. § 438.610(a) and (b); or (ii) any individual or entity that would provide those services through an individual or entity described in 42 C.F.R. § 438.610(a) and (b);

10.4 excluded from participation in federal health care programs under either section 1128 or section 1128A of the Social Security Act; or

10.5 excluded from participation by the Department of Health and Human Services ("DHHS"), Office of Inspector General (OIG) under section 1128 of the Social Security Act, or by the Agency from participating in the Iowa Medicaid program for fraud or abuse.

Upon the giving of written notice, the Health Plan may immediately terminate its relationship with any Participating Provider identified as in continued violation of law by the Agency.

11. Disclosure of Information on Ownership and Control. If Participating Provider is a disclosing entity, fiscal agent, or network provider (as defined by federal regulation), this Section applies.

11.1 Ownership Information. Participating Provider must provide the name and address of any person (individual or corporation) with an ownership or control interest in the disclosing entity, fiscal agent, or network provider. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.

11.2 Provider Information. Participating Provider must provide the date of birth and social security number (in the case of an individual).

11.3 Provider Tax Identification Number. Participating Provider must provide other tax identification number (in the case of a corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or network provider) or in any Subcontractor in which the disclosing entity (or fiscal agent or network provider) has a 5 percent or more interest.

11.4 Related Party Information. Participating Provider must disclose information regarding whether the person (individual or corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or network provider) is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any Subcontractor in which the disclosing entity (or fiscal agent or network provider) has a five percent or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.

11.5 Other Disclosing Entity Information. Participating Provider must provide the name of any other disclosing entity (or fiscal agent or network provider) in which an owner of the disclosing entity (or fiscal agent or network provider) has an ownership or control interest.

11.6 Managing Employee Information. Participating Provider must provide the name, address, date of birth, and social security number of any managing employee of the disclosing entity (or fiscal agent or network provider).

11.7 Timing of Disclosures for Disclosing Entity. If Participating Provider is a network provider or disclosing entity, it, he or she shall provide such disclosures at the following times: (a) upon submitting the provider application; (b) upon executing the Agreement; (c) upon request of the Agency during the re-validation of enrollment process; and (d) within 35 days after any change in ownership of the disclosing entity or network provider.

11.8 Timing of Disclosures for Fiscal Agent. If Participating Provider is a fiscal agent, it shall provide such disclosures at the following times: (a) upon the fiscal agent submitting the proposal in accordance with the procurement process; (b) upon the fiscal agent executing the Agreement; (c) upon renewal or extension of the contract with a fiscal agent; and (d) within 35 days after any change in ownership of the fiscal agent.

11.9 Failure to Disclose. Federal financial participation ("FFP") is not available in payments made to a disclosing entity that fails to disclose ownership or control information as required by this Section.

12. Provider Business Transactions.

12.1. Business Transaction Information. Each Participating Provider agrees to furnish to Health Plan, the Agency or the DHHS Secretary on request information related to business transactions in accordance with this Section. Each Participating Provider must submit, within 35 days of the date on a request by the Secretary, the Agency or the Health Plan, full and complete information about the following: (a) the ownership of any Subcontractor with whom the Participating Provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and (b) any significant business transactions between the Participating Provider and any wholly owned supplier, or between the Participating Provider and any Subcontractor, during the 5-year period ending on the date of the request.

12.2. Failure to Disclose. FFP is not available in expenditures for services furnished by providers who fail to comply with a request made by the Secretary, the Agency, or the Health Plan under this section or under 42 C.F.R. § 420.205. FFP will be denied in expenditures for services furnished during the period beginning on the day following the date the information was due to the Secretary, the Agency, or the Health Plan and ending on the day before the date on which the information was supplied.

13. Persons Convicted of Crimes; Denial or Termination of Participation. Before the Health Plan enters into or renews a provider agreement, or at any time upon written request by DHHS, the Agency, or the Health Plan, each Participating Provider shall disclose to Health Plan and the Agency the identity of any person who: (a) has ownership or control interest in the Participating Provider, or is an agent or managing employee of the Participating Provider; and (b) has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the title XX services program since the inception of those programs. The Health Plan may refuse to enter into or renew an agreement with a Participating Provider, and the Agency may refuse to allow the Health Plan to renew or enter into such an agreement if any person who has an ownership or control interest in the Participating Provider, or who is an agent or managing employee of the Participating Provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the Title XXI Services Program. The Health Plan may refuse to enter into or may terminate a provider agreement and the Agency may refuse to allow the Health Plan to renew or enter into such an agreement if any of the Health Plan, Agency or DHHS determines that the Provider did not fully and accurately make any disclosure required under this Section.

14. Use of Third Parties. All restrictions, obligations, and responsibilities of the Health Plan under the State Contract also apply to the subcontractors of Health Plan (including each Participating Provider). The Agency has the right to request the removal of a subcontractor (including a Participating Provider) from participating under the State Contract for good cause.

15. Cost Sharing and Patient Liability. Participating Provider (and its, his or her subcontractors) shall not require any cost sharing or patient liability responsibilities for Covered Services except to the extent that cost sharing or patient liability responsibilities are required for those services in accordance with law and as described in the State Contract. Further, Participating Provider (and its, his or her subcontractors) shall not charge Covered Persons for missed appointments.

16. Community-Based Care Management Requirements. Provider shall comply with the following requirements with respect to those Covered Persons receiving home and community-based long term services and supports to whom Health Plan has assigned to a community-based case manager:

16.1 External Communication and Coordination. Provider shall, as applicable, notify a community-based case manager, as expeditiously as warranted by the Covered Person's circumstances, of any significant changes in the Covered Person's condition or care, hospitalizations, or recommendations for additional services.

16.2 Transitions Between Facilities. Subject to approval by the Agency, Provider shall not, as applicable, engage in the involuntary discharge of a Covered Person that may lead to a placement in an inappropriate or more restrictive setting.

17. Copayments - Exempt Populations. In accordance with 42 CFR 447.56, Provider shall not impose co-payments for the following populations:

17.1. Individuals between ages one (1) and eighteen (18) who are eligible under 42 CFR 435.118;

17.2. Individuals under age one (1) who are eligible under 42 CFR 435.118;

17.3. Disabled or blind individuals under age eighteen (18) who are eligible under 42 CFR 435.120 or 42 CFR 435.130;

17.4. Children for whom child welfare services are made available under Part B of title IV of the Social Security Act on the basis of being a child in foster care and individuals receiving benefits under Part E of that title, without regard to age;

17.5. Disabled children eligible for Medicaid under the Family Opportunity Act;

17.6. Pregnant women, during pregnancy and through the postpartum period which begins on the last day of pregnancy and extends through the end of the month in which the sixty (60) day period following termination of pregnancy ends;

17.7. Any individual whose medical assistance for services furnished in an institution is reduced by amounts reflecting available income other than required for personal needs;

17.8. An individual receiving hospice care, as defined in section 1905(o) of the Social Security Act;

17.9. An Indian (as defined at 42 CFR 447.51) who is currently receiving or has ever received an item or service furnished by an Indian health care provider or through referral under contract health services; and

17.10. Individuals who are receiving Medicaid by virtue of their breast or cervical cancer diagnosis under 42 CFR §435.213.

18. Copayments - Exempt Services. Provider shall not impose co-payments for the following: (i) preventive services provided to children under age eighteen (18); (ii) pregnancy-related services, including those defined at 42 CFR 440.210(a)(2) and 440.250(p) and counseling for cessation of tobacco use; (iii) provider preventable services as defined at 42 CFR 447.26(b); and (iv) family planning services and supplies described in section 1905(a)(4)(C) of the Social Security Act.

19. Non-Emergency Use of Emergency Room. If Provider is a hospital, before providing non-emergency treatment and imposing cost-sharing for such services on a Covered Person, Provider shall:

19.1 Inform the Covered Person of the amount of his or her cost sharing obligation for non-emergency services provided in the emergency department;

19.2 Provide the Covered Person with the name and location of an available and accessible alternative non-emergency services provider. If geographical or other circumstances prevent Provider from meeting this requirement, cost-sharing may not be imposed;

19.3 Determine that the alternative provider can provide services to the Covered Person in a timely manner with the imposition of a lesser cost sharing amount. The assessment of access to timely services must be based on the medical needs of the Covered Person; and

19.4 Provide a referral to coordinate scheduling for treatment by the alternative provider.

20. Inability to Pay. Provider may not deny care or services to any Covered Person because of his or her inability to pay an applicable copayment.

21. Provider Network. Each Participating Provider shall: (a) meet Agency standards for timely access to care and services, taking into account the urgency of the need for services; (b) ensure that it offers hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the Participating Provider serves only Medicaid enrollees; (c) make services included in the State Contract available 24 hours a day, 7 days a week, when Medically Necessary; (d) establish mechanisms to ensure compliance with the State Contract; and (e) monitor its operations regularly to determine compliance with the State Contract.

22. Provider Agreements Generally.

22.1. Governing Documents. Each Participating Provider agrees that all applicable terms and conditions set out in the State Contract, any incorporated documents and all applicable State and federal laws, as amended, govern the duties and responsibilities of the Participating Provider with regard to the provision of services to Covered Persons.

22.2. Continuation of Benefits. Each Participating Provider agrees to ensure continuation of benefits in accordance with the terms of the Agreement and the State Contract.

22.3. Agency Enrollment. Each Participating Provider warrants and represents that it is enrolled with the Agency, which is a condition for participation in the Health Plan's network.

22.4. Business Associate Agreement. When applicable, Provider agrees to execute a business associate agreement.

22.5. Third Party Liability. Each Participating Provider's responsibility regarding third party liability is set forth in the Agreement or the Provider Manual. At a minimum, Participating Provider shall identify third party liability coverage, including Medicare and long-term care insurance as applicable, and except as otherwise required, seek such third party liability payment before submitting claims to Payor.

22.6. Claim Submission. Each Participating Provider shall submit claims in accordance with the terms of the Agreement and the Provider Manual, and, for those that do not involve a third party payer, within one hundred eighty (180) days of the date of service.

22.7. Encounter Data. If Participating Provider is paid on a capitated basis, Participating Provider shall submit encounter data within ninety (90) days of the date of service. As applicable, the Agreement will comply with the requirements set forth for subcontracts as outlined in this Attachment and in accordance with 42 C.F.R. § 434.6.

23. Nursing Facility Provider Agreements. If Participating Provider is a nursing facility, this Section applies.

23.1 Notice of Admissions. Participating Provider shall promptly notify the Health Plan or Payor, as applicable, of a Covered Person's admission or request for admission to the nursing facility as soon as Participating Provider has knowledge of such admission or request for admission.

23.2 Health Plan Notice of Discharges. Participating Provider shall notify the Health Plan or Payor, as applicable, immediately if the nursing facility is considering discharging a Covered Person and shall consult with the Covered Person's care coordinator.

23.3 Covered Person Notice of Discharges. Participating Provider shall notify the Covered Person and/or the Covered Person's representative (if applicable) in writing prior to discharge in accordance with State and federal requirements.

23.4 Collection of Patient Liability. Participating Provider agrees to collect patient liability (also referred to as client participation) amounts. The Health Plan or Payor will notify the Participating Provider of the patient liability amounts that Participating Provider must collect from the Covered Person before Medicaid reimbursement for services is available. Payor is only responsible for paying Participating Provider net of the applicable patient liability amount and otherwise in accordance with the terms of the Agreement.

23.5 Notice of Change in Condition. Participating Provider shall notify the Health Plan or Payor, as applicable, of any change in a Covered Person's medical or functional condition that could impact the Covered Person's level of care eligibility for the currently authorized level of nursing facility services.

23.6 PASRR Requirements. Participating Provider shall comply with federal Preadmission Screening and Resident Review (PASRR) requirements to provide or arrange to provide specialized services and all applicable State law governing admission, transfer and discharge policies.

23.7 Termination Due to Decertification. If Participating Provider is involuntarily decertified by the State or CMS, the Agreement is automatically terminated in accordance with federal requirements.

24. HCBS Providers. If Participating Provider is a Home and Community-Based Services ("HCBS") provider, this Section applies.

24.1 Notice of Provider Change. Participating Provider shall provide at least thirty (30) days advance notice to Health Plan or Payor, as applicable, when the provider is no longer willing or able to provide services to a Covered Person, and shall cooperate with the Covered Person's care coordinator to facilitate a seamless transition to alternate providers.

24.2 Continuation of Services. In the event that a HCBS provider change is initiated for a Covered Person, regardless of any other provision in the Agreement, the transferring Participating Provider will continue to provide services to the Covered Person in accordance with the Covered Person's plan of care until the Covered Person has been transitioned to a new provider, as determined by the Health Plan, or as otherwise directed by the Health Plan, which may exceed thirty (30) days from the date of notice to the Health Plan.

24.3 Notice of Deviations. Participating Provider shall immediately report any deviations from a Covered Person's service schedule to the Covered Person's care coordinator.

24.4 Critical Incident Reporting. Participating Provider shall comply with the critical incident reporting requirements as described in this Attachment.

24.5 Abuse Reporting. Participating Provider shall comply with child and dependent adult abuse reporting requirements.

25. LTSS Providers. If Provider is an LTSS provider, Provider's service delivery site or services shall meet all applicable requirements of State Regulatory Requirements and have the necessary and current licenses, certification, accreditation, and/or designation approval per State requirements. When individuals providing LTSS are not required to be licensed, accredited or certified, Provider shall ensure that such individuals are appropriately educated, trained, qualified, and competent to perform their job responsibilities based on applicable State licensure rules and/or program standards.

26. Substance Use Disorder Providers. If Provider will provide substance use disorder services to Covered Persons hereunder, Provider shall ensure that such substance use disorder treatment services are provided by programs licensed by IDPH in accordance with Iowa Code chapter 125 or by hospital-based substance use disorder treatment programs licensed and accredited in accordance with Iowa Code section 125.13.2(a).

27. Non-Licensed Providers. If Provider or any Contracted Provider is not required to be licensed or certified to provide Covered Services hereunder, Provider shall ensure, based on applicable State licensure rules and/or program standards, that Provider and/or Contracted Provider, as applicable, is appropriately educated, trained, qualified and competent to perform their job responsibilities.

28. Critical Incidents. Each Participating Provider shall: (a) report critical incidents; (b) respond to critical incidents; (c) document critical incidents; and (d) to cooperate with any investigation conducted by the Health Plan, Payor or outside agency.

29. Medical Records. Each Participating Provider shall comply with Health Plan's policies and procedures for medical records content and documentation, including the requirements of Iowa Admin. Code 441 Chapter 79.3. Each Participating Provider shall document all medical services that the Covered Person receives in accordance with law and consistent with utilization control requirements in 42 C.F.R. Part 456. Each Participating Provider shall maintain Covered Persons' medical records in a detailed and comprehensive manner that conforms to good professional medical practice, permits effective professional medical review and medical audit processes, and facilitates an accurate system for follow-up treatment. Each Participating Provider shall ensure that medical records are legible, signed, dated and maintained as required by law. Each Participating Provider shall protect and maintain the confidentiality of mental health information, including by releasing mental health information only as allowed by Iowa Code §228. Further, each Participating Provider shall protect and maintain the confidentiality of substance use disorder information, including by releasing substance use disorder information only in compliance with policies set forth in 42 C.F.R. Part 2 and other applicable State and federal law and regulations.

30. Member Rights. Each Participating Provider shall provide a copy of a Covered Person's medical record upon reasonable request by the Covered Person at no charge, and the Participating Provider shall facilitate the transfer of the Covered Person's medical record to another provider at the Covered Person's request. Confidentiality of, and access to, medical records shall be provided in accordance with the standards mandated in the Health Insurance Portability and Accountability Act (HIPAA) and all other State and federal requirements.

31. Access to Medical and Financial Records. Within the timeframe designated by the Agency or other authorized entity, each Participating Provider will permit the Health Plan, Payor, representatives of the Agency, and other authorized entities to review Covered Persons' records for the purposes of monitoring the Participating Provider's compliance with the record standards, capturing information for clinical studies, monitoring quality or any other reason.

32. Availability of Services. Provider shall offer hours of operation that are no less than the hours of operation offered to commercial members, or, if Provider serves only the Medicaid population, to comparable Medicaid members. Provider shall make Covered Services available twenty four (24) hours a day, seven (7) days a week, when medically necessary.

33. Rights of Covered Person. Provider shall comply with federal and State Regulatory Requirements and regulations that pertain to the rights of Covered Persons and shall take those rights into account when furnishing services to Covered Persons.

34. Provider Incentive Program. Provider acknowledges and agrees that Health Plan is required under the terms of the State Contract to provide information concerning any physician incentive plan with Provider to Covered Persons upon request and in any marketing materials, in accordance with the disclosure requirements stipulated in federal regulations. Provider hereby waives any confidentiality obligations with respect to such disclosure of such information.

35. Critical Incidents. Provider shall: (i) report critical incidents; (ii) respond to critical incidents; (iii) document critical incidents; and (iv) cooperate with any investigation conducted by Health Plan or an outside agency and with any strategy implemented by Health Plan to reduce the occurrence of critical incidents and improve the quality of care delivered to Covered Persons.

36. Provider Preventable Conditions. In accordance with 42 CFR 438.6(f)(2) and 42 CFR 434.6(a)(12), Health Plan shall make no payment to Provider or any Contracted Provider for any provider-preventable condition as identified in the State Plan. As a condition of payment, in accordance with 42 CFR 447.26(d), Provider shall comply with the reporting requirements set forth at 42 CFR 447.26(d).

37. Twenty four (24) Hour Availability Audit. Provider must be available to Covered Persons twenty-four (24) hours-a-day, seven (7) days-a-week. Provider shall comply with any corrective actions implemented by Health Plan in the event an audit shows that Provider fails to meet this standard.

38. Provider's Duties Upon Termination of State Contract. In the event of termination of the State Contract, Provider shall arrange for the orderly transfer of patient care and patient records to those providers who will assume care for each applicable Covered Person. For those Covered Persons who are in a course of treatment for which a change of providers could be harmful, Provider shall continue to provide Covered Services to such Covered Persons until that treatment is concluded or appropriate transfer of care can be arranged.

39. Provider Access and Appointment Times. Provider shall provide necessary and appropriate services to Covered Persons within a timely period, as indicated below.

39.1 PCP Services. If Provider is a PCP, appointment times shall not exceed four (4) to six (6) weeks from the date of a Covered Person's request for a routine appointment; forty-eight (48) hours for persistent symptoms; and one (1) day for urgent care.

39.2 Specialty Services. If Provider provides specialty services, appointment times shall not exceed thirty (30) days from the date of a Covered Person's request or one (1) day for urgent care.

40. Behavioral Health Services. If Provider is a behavioral health provider, Provider shall have procedures for the scheduling of Covered Person appointments in accordance with the following requirements:

40.1. Emergency. Covered Persons with emergency needs shall be seen within fifteen (15) minutes of presentation at a service delivery site.

40.2. Mobile Crisis. Covered Persons in need of mobile crisis services shall receive services within one (1) hour of presentation or request.

40.3. Urgent. Covered Persons with urgent non-emergency needs shall be seen by an appropriate provider within one (1) hour of presentation at a service delivery site or within twenty-four (24) hours of telephone contact with Participating Provider or the Health Plan.

40.4. Persistent Symptoms. Covered Persons with persistent symptoms shall be seen by an appropriate provider within forty-eight (48) hours or reporting symptoms.

40.5. Routine. Covered Persons with need for routine services shall be seen by an appropriate provider within three (3) weeks of the request for an appointment.

40.6. Substance Use Disorder and Pregnancy. Covered Persons who are pregnant women in need of routine substance use disorder services must be admitted within forty-eight (48) hours of seeking treatment.

40.7. Intravenous Drug Use. Covered Persons who are intravenous drug users must be admitted not later than fourteen (14) days after making the request for admission, or one-hundred and twenty (120) days after the date of such request if no program has the capacity to admit the individual on the date of such request and if interim services are made available to the individual not later than forty-eight (48) hours after such request.

41. Emergency Services. If Provider is a hospital, all Emergency Care shall be provided immediately at the nearest facility available regardless of whether the facility or provider is under contract with Health Plan.

42. Optometry Services. If Provider provides general optometry services, appointment times shall not exceed three (3) weeks from the date of a Covered Person's request for a regular appointment and forty-eight (48) hours for urgent care.

43. Laboratory and X-Ray Services. If Provider or provides laboratory or X-ray services, appointment times shall not exceed three (3) weeks from the date of a Covered Person's request for a regular appointment and forty-eight (48) hours for urgent care.

44. Fraud, Waste and Abuse. If Provider is a Subcontractor that is delegated responsibility by the Health Plan for coverage of services and payment of claims under the State Contract, Provider shall implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse. Such arrangements or procedures will, at a minimum, include the requirements set forth in the State Contract.

45. Overpayments. Each Participating Provider shall report to the Payor, when it has received an overpayment, return the overpayment to the Payor within 60 calendar days after the date on which the overpayment was identified, and notify the Payor in writing of the reason for the overpayment.

Attachment A: Medicaid

SCHEDULE B
REGULATORY REQUIREMENTS

This Schedule B to Attachment A, State-Mandated Provisions, ("***Attachment A***") is incorporated into the Participating Provider Agreement ("***Agreement***") entered into by and between City of West Des Moines ("***Provider***") and Iowa Total Care, Inc. ("Health Plan") as of the Effective Date. Health Plan and Provider shall comply with the following provision, which is required by State law to be included in this Agreement, to the extent applicable and as such, this provision may be amended from time to time in accordance with the Agreement. In the event of a conflict between the terms and conditions of the Agreement and the terms and conditions of this Attachment A, this Attachment A will govern.

1. Definitions. For purposes of this Attachment A, the following terms have the meanings set forth below. Capitalized terms used in this Attachment A and not defined below will have the same meaning set forth in the Agreement.

1.1 "***State***" means the State of Iowa.

2. Hold Harmless. Contracted Provider or its assignee or subcontractor, hereby agrees that in no event, including, but not limited to nonpayment by the Health Plan, Health Plan insolvency or breach of this agreement, shall Contracted Provider, or its assignee or subcontractor, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against enrollee or persons other than the Health Plan acting on their behalf for services provided pursuant to this Agreement. This provision shall not prohibit collection of supplemental charges or copayments on Health Plan's behalf made in accordance with terms of the High Quality Healthcare Initiative Agreement between Health Plan and the State. Contracted Provider, or its assignee or subcontractor, further agrees that (1) 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 Health Plan enrollee and that (2) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Contracted Provider and enrollee or persons acting on their behalf. (IAC 191-40.18(514B))

Attachment A: Medicaid

COMPENSATION SCHEDULE
ANCILLARY SERVICES
AMBULANCE

City of West Des Moines

EXHIBIT 1

This compensation schedule ("Compensation Schedule") sets forth the maximum reimbursement amounts for Covered Services provided by Contracted Providers to Covered Persons enrolled in a Medicaid Product. Where the Contracted Provider's tax identification number ("TIN") has been designated by the Payor as subject to this Compensation Schedule, Payor shall pay or arrange for payment of a Clean Claim for Covered Services rendered by the Contracted Provider according to the terms of, and subject to the requirements set forth in, the Agreement and this Compensation Schedule. Payment under this Compensation Schedule shall consist of the Allowed Amount as set forth herein less all applicable Cost-Sharing Amounts. All capitalized terms used in this Compensation Schedule shall have the meanings set forth in the Agreement, the applicable Product Attachment, or the Definitions section set forth at the end of this Compensation Schedule.

The maximum compensation for ambulance Covered Services rendered to a Covered Person shall be the "Allowed Amount." Except as otherwise provided in this Compensation Schedule, the Allowed Amount for ambulance Covered Services is the lesser of: (i) Allowable Charges; or (ii) one hundred percent (100%) of the State's Medicaid fee schedule in effect on the date of service.

Additional Provisions:

1. Code Change Updates. Payor utilizes nationally recognized coding structures (including, without limitation, revenue codes, CPT codes, HCPCS codes, ICD codes, national drug codes, ASA relative values, etc., or their successors) for basic coding and descriptions of the services rendered. Updates to billing-related codes shall become effective on the date ("Code Change Effective Date") that is the later of: (i) the first day of the month following sixty (60) days after publication by the governmental agency having authority over the applicable Product of such governmental agency's acceptance of such code updates, (ii) the effective date of such code updates as determined by such governmental agency or (iii) if a date is not established by such governmental agency or the applicable Product is not regulated by such governmental agency, the date that changes are made to nationally recognized codes. Such updates may include changes to service groupings. Claims processed prior to the Code Change Effective Date shall not be reprocessed to reflect any such code updates.

2. Fee Change Updates. Updates to the fee schedule shall become effective on the effective date of such fee schedule updates, as determined by the Payor ("Fee Change Effective Date"). The date of implementation of any fee schedule updates, i.e. the date on which such fee change is first used for reimbursement ("Fee Change Implementation Date"), shall be the later of: (i) the first date on which Payor is reasonably able to implement the update in the claims payment system; or (ii) the Fee Change Effective Date. Claims processed prior to the Fee Change Implementation Date shall not be reprocessed to reflect any updates to such fee schedule, even if service was provided after the Fee Change Effective Date.

3. Fee Sources. In the event the State's Medicaid fee schedule contains no published fee amount (e.g., a zero or a blank), alternate (or "gap fill") fee sources may be used to supply the fee basis amount for deriving fee amount (the "Alternative Fee Source Amount"). Health Plan will utilize such Alternative Fee Source Amount until such time that the State's Medicaid fee schedule publishes its own RBRVS value. At such time in the future as the State's Medicaid fee schedule publishes its own RBRVS value for that CPT/HCPCS code, Payor will use the State's Medicaid fee schedule fee amount for that code and no longer use the Alternate Fee Source Amount. If there is no established payment amount on the current State's Medicaid fee schedule for a gap fill fee source is not available for a Covered Service provided to a Covered Person, Payor may establish a payment amount to

apply in determining the Allowed Amount. Until such time as Payor establishes such a payment amount, the maximum compensation shall be twenty five percent (25%) of Allowable Charges.

4. Billing Requirements. Contracted Provider must bill HCPCS codes in addition to revenue code for services specified within this Compensation Schedule. Failure to submit a HCPCS code may result in a claim denial.

5. Date of Service Requirements. Contracted Provider is required to identify each date of service on claims for multiple dates of service.

6. Carve-Out Services. With respect to any "Carve-Out" Covered Services as contemplated in this Agreement, any payment arrangement entered into between Provider and a third party vendor of such services shall supersede compensation hereunder.

7. Payment under this Compensation Schedule. All payments under this Compensation Schedule are subject to the terms and conditions set forth in the Agreement, the Provider Manual and any applicable billing manual and claims processing policies.

Definitions:

1. **Allowed Amount** means the amount designated in this Compensation Schedule as the maximum amount payable to a Contracted Provider for any particular Covered Service provided to any particular Covered Person, pursuant to this Agreement or its Attachments.

2. **Allowable Charges** means a Contracted Provider's billed charges for services that qualify as Covered Services.

3. **Cost-Sharing Amounts** means any amounts payable by a Covered Person, such as copayments, cost-sharing, coinsurance, deductibles or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement, if applicable.

Attachment C: Commercial-Exchange

PRODUCT ATTACHMENT
(INCLUDING REGULATORY REQUIREMENTS AND COMPENSATION SCHEDULE)

THIS PRODUCT ATTACHMENT (this "***Product Attachment***") is made and entered between Iowa Total Care, Inc. ("***Health Plan***") and Provider.

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

WHEREAS, pursuant to the provisions of the Agreement, this Product Attachment is identified on Schedule B of the Agreement and, as such, the Contracted Providers identified herein will be designated and participate as "Participating Providers" in the commercial and exchange Products described in this Product Attachment as Downstream Entities as defined in this Product Attachment; and

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

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

1. Defined Terms. For purposes of the Commercial-Exchange Product, the following terms have the meanings set forth below. All capitalized terms not specifically defined in this Attachment will have the meanings given to such terms in the Agreement.

1.1 "***Commercial-Exchange Product***" refers to those programs and health benefit arrangements offered by a Company that provide incentives to Covered Persons to utilize the services of certain contracted providers. The Commercial-Exchange Product includes those Coverage Agreements entered into, issued or agreed to by a Payor under which a Company furnishes administrative services or other services in support of a health care program for an individual or group of individuals, which may include access to one or more of the Company's provider networks or vendor arrangements, and which may be provided in connection with a state or governmental-sponsored, employer-sponsored or other private health insurance exchange, except those excluded by Health Plan. The Commercial-Exchange Product does not apply to any Coverage Agreements that are specifically covered by another Product Attachment to the Agreement.

1.2 "***Delegated Entity***" means any party, including an agent or broker, that enters into an agreement with Health Plan to provide administrative services or health care services to qualified individuals, qualified employers or qualified employees and their dependents (as such terms are defined in 45 C.F.R. §156.20).

1.3 "***Downstream Entity***" means any party, including an agent or broker, that enters into an agreement with a Delegated Entity or with another Downstream Entity for purposes of providing administrative or health care services related to the agreement between the Delegated Entity and Health Plan. The term "Downstream Entity" is intended to reach the entity that directly provides administrative services or health care services to qualified individuals, qualified employers, or qualified employees and their dependents (as such terms are defined in 45 C.F.R. §156.20).

1.4 "***Emergency" or "Emergency Care***" has the meaning set forth in the Covered Person's Coverage Agreement.

1.5 "***Emergency Medical Condition***" has the meaning set forth in the Covered Person's Coverage Agreement.

1.6 "***State***" means the State of Iowa, or such other state to the extent that a Coverage Agreement or Covered Person is subject to such other state's law.

2. Commercial-Exchange Product. This Product Attachment constitutes the "Commercial-Exchange Product Attachment" and is incorporated into the Agreement between Provider and Health Plan. It supplements the

Agreement by setting forth specific terms and conditions that apply to the Commercial-Exchange Product with respect to which a Participating Provider has agreed to participate, and with which a Participating Provider must comply in order to maintain such participation. This Product Attachment applies with respect to the provision of health care services, supplies or accommodations (including Covered Services) to Covered Persons enrolled in or covered by a Commercial-Exchange Product.

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

4. Attachments. This Product Attachment includes, at Schedule A, the Regulatory Requirements with which Participating Providers are required to comply based on State laws governing the applicable Coverage Agreement or Covered Person and at the Compensation Schedule Exhibit(s) for the Commercial-Exchange Product, each of which are incorporated herein by reference.

5. Construction. This Product Attachment supplements and forms a part of the Agreement. Except as otherwise provided herein or in the terms of the Agreement, the terms and conditions of the Agreement will remain unchanged and in full force and effect as a result of this Product Attachment. In the event of a conflict between the provisions of the Agreement and the provisions of this Product Attachment, this Product Attachment will govern with respect to health care services, supplies or accommodations (including Covered Services) rendered to Covered Persons enrolled in or covered by a Commercial-Exchange Product. To the extent Provider or any Contracted Provider is unclear about its, his or her respective duties and obligations, Provider or the applicable Contracted Provider shall request clarification from the Company.

6. Term. This Product Attachment will become effective as of the Effective Date, and will be coterminous with the Agreement unless a Party terminates the participation of the Contracted Provider in this Commercial-Exchange Product in accordance with the applicable provisions of the Agreement or this Product Attachment.

7. Federal Requirements. The following requirements apply to Delegated and Downstream Entities under this Commercial Exchange Product Attachment, which includes but is not limited to Provider and all Contracted Providers.

7.1 Provider's delegated activities and reporting responsibilities, if any, are specified in the Agreement or applicable attachment to the Agreement (e.g., Delegated Credentialing Agreement, Delegated Services Agreement, Statement or Work, or other scope of services attachment) attached to this Agreement. If such attachment is not executed, no administrative functions shall be deemed as delegated.

7.2 CMS, Health Plan and Payor reserve the right to revoke the delegation activities and reporting requirements or to specify other remedies in instances where CMS, Health Plan or the Payor determine that Provider or any Downstream Entity has not performed satisfactorily.

7.3 Provider and all Downstream Entities must comply with all applicable laws and regulations relating to the standards specified under 45 CFR §156.340(a);

7.4 Provider and all Downstream Entities must permit access by the Secretary and OIG or their designees in connection with their right to evaluate through audit, inspection or other means, to the Provider's or Downstream Entities' books, contracts, computers, or any other electronic systems including medical records and documentation, relating to Health Plan's obligations in accordance with federal standards under 45 CFR §156.340(a) until ten (10) years from the termination date of this Product Attachment.

8. Other Terms and Conditions. Except as modified or supplemented by this Attachment, the compensation hereunder for the provision of Covered Services by Contracted Providers to Covered Persons enrolled in or covered by this Product is subject to all of the other provisions in the Agreement (including the Provider Manual) that affect or relate to compensation for Covered Services provided to Covered Persons.

Attachment C: Commercial-Exchange

SCHEDULE A
REGULATORY REQUIREMENTS

This Schedule sets forth the provisions that are required by State law to be included in the Agreement with respect to this Product. Any additional Regulatory Requirements that may apply to the Coverage Agreements or Covered Persons enrolled in or covered by this Product are or will be set forth in the Provider Manual or another Attachment. To the extent that a Coverage Agreement, or a Covered Person, is subject to the law cited in the parenthetical at the end of a provision on this Schedule A, such provision will apply to the rendering of Covered Services to a Covered Person with such Coverage Agreement, or to such Covered Person, as applicable.

IA-1 Records Available. Participating Provider agrees that the Commissioner shall have access to make an examination of Participating Providers as often as the Commissioner deems necessary for the protection of the interests of the people of Iowa, but not less frequently than once every five years. Participating Provider shall submit its books and records to the Commissioner and in every way facilitate the examination. (IOWA CODE § 514B.24)

IA-2 Provider Assurances. Participating Provider shall ensure that they meet applicable licensure requirements by the appropriate state agency where they are located, and Participating Provider shall be either accredited by The Joint Commission or the American Osteopathic Association; or they shall be certified as a provider for Medicare or Medicaid, as applicable. (IOWA ADMIN CODE § 191-40.5(4))

IA-3 Contract Submission. Participating Provider acknowledge and agree that all arrangements of Payor for health care services must be by written contract; initial provider contracts are subject to prior approval; and any provider contract deviating from previously submitted or approved contracts must be submitted to (and in certain cases approved by) the Insurance Division. (IOWA ADMIN CODE §§ 191-40.18; 191-27.5(3))

IA-4 Hold Harmless. Participating Provider agrees that in no event, including but not limited to nonpayment by the Payor, Payor insolvency or breach of the Agreement, shall Participating Provider, or their respective assignees or subcontractors, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Covered Persons other than the Payor acting on their behalf for Covered Services provided pursuant to the Agreement. This provision will not prohibit the collection of supplemental charges or copayments on the Payor's behalf made in accordance with terms of the Coverage Agreement. Participating Provider agrees that this provision will survive the termination of the Agreement or this Exhibit regardless of the cause giving rise to termination, and shall be construed to be for the benefit of the Covered Persons. Participating Provider further agrees that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Participating Provider and Covered Persons or persons acting on Covered Persons' behalf. (IOWA ADMIN CODE § 191-40.18)

IA-5 No Discouragement. Participating Provider is not prohibited from and will not be penalized for discussing treatment options with Covered Persons, irrespective of a Payor's position on the treatment options. Participating Provider is not prohibited from and will not be penalized for advocating on behalf of Covered Persons within the utilization review or grievance processes established by a Payor or a person contracting with a Payor. (IOWA ADMIN CODE §§ 191-40.22(1); 191-27.8(1))

IA-6 No Penalization. Participating Provider will not be penalized for reporting, in good faith, to State or federal authorities any act or practice by a Payor that, in the opinion of Participating Provider, jeopardizes patient health or welfare. (IOWA ADMIN CODE §§ 191-40.22(2); 191-27.8(2))

IA-7 Preferred Provider Arrangements. Participating Provider acknowledges and agrees that this Agreement: (i) establishes the amount and manner of payment to Participating Provider; (ii) includes mechanisms that are designed to minimize the cost of the Coverage Agreement, which may include, but are not limited to, the review or control of utilization of health care costs and a procedure for determining whether services rendered are

Medically Necessary; and (iii) ensures reasonable access to Covered Services. Participating Provider further acknowledges and agrees that this Agreement does not and shall not be construed to unfairly deny health benefits for Medically Necessary Covered Services. (IOWA ADMIN CODE § 191-27.3(1), (2))

IA-8 Prescription Drug Formulary. Participating Provider hereby acknowledges the existence of a prescription drug formulary applicable to Coverage Agreements. (IOWA ADMIN CODE § 191-40.23)

Attachment C: Commercial-Exchange

COMPENSATION SCHEDULE
ANCILLARY SERVICES
AMBULANCE

City of West Des Moines

EXHIBIT 1

This compensation schedule ("Compensation Schedule") sets forth the maximum reimbursement amounts for Covered Services provided by Contracted Providers to Covered Persons enrolled in a Commercial-Exchange Product. Where the Contracted Provider's tax identification number ("TIN") has been designated by the Payor as subject to this Compensation Schedule, Payor shall pay or arrange for payment of a Clean Claim for Covered Services rendered by the Contracted Provider according to the terms of, and subject to the requirements set forth in, the Agreement and this Compensation Schedule. Payment under this Compensation Schedule shall consist of the Allowed Amount as set forth herein less all applicable Cost-Sharing Amounts. All capitalized terms used in this Compensation Schedule shall have the meanings set forth in the Agreement, the applicable Product Attachment, or the Definitions section set forth at the end of this Compensation Schedule.

The maximum compensation for ambulance Covered Services rendered to a Covered Person shall be the "Allowed Amount." Except as otherwise provided in this Compensation Schedule, the Allowed Amount for ambulance Covered Services is the lesser of: (i) Allowable Charges; or (ii) one hundred percent (100%) of the Payor's Medicare fee schedule.

Additional Provisions:

1. Code Change Updates. Payor utilizes nationally recognized coding structures (including, without limitation, revenue codes, CPT codes, HCPCS codes, ICD codes, national drug codes, ASA relative values, etc., or their successors) for basic coding and descriptions of the services rendered. Updates to billing-related codes shall become effective on the date ("Code Change Effective Date") that is the later of: (i) the first day of the month following sixty (60) days after publication by the governmental agency having authority over the applicable Product of such governmental agency's acceptance of such code updates, (ii) the effective date of such code updates as determined by such governmental agency or (iii) if a date is not established by such governmental agency or the applicable Product is not regulated by such governmental agency, the date that changes are made to nationally recognized codes. Such updates may include changes to service groupings. Claims processed prior to the Code Change Effective Date shall not be reprocessed to reflect any such code updates.

2. Fee Change Updates. Updates to the fee schedule shall become effective on the effective date of such fee schedule updates, as determined by the Payor ("Fee Change Effective Date"). The date of implementation of any fee schedule updates, i.e. the date on which such fee change is first used for reimbursement ("Fee Change Implementation Date"), shall be the later of: (i) the first date on which Payor is reasonably able to implement the update in the claims payment system; or (ii) the Fee Change Effective Date. Claims processed prior to the Fee Change Implementation Date shall not be reprocessed to reflect any updates to such fee schedule, even if service was provided after the Fee Change Effective Date.

3. Billing Requirements. Contracted Provider must bill HCPCS codes in addition to revenue code for services specified within this Compensation Schedule. Failure to submit a HCPCS code may result in a claim denial.

4. Date of Service Requirements. Contracted Provider is required to identify each date of service on claims for multiple dates of service.

5. Carve-Out Services. With respect to any "Carve-Out" Covered Services as contemplated in this Agreement, any payment arrangement entered into between Provider and a third party vendor of such services shall supersede compensation hereunder.

6. Payment under this Compensation Schedule. All payments under this Compensation Schedule are subject to the terms and conditions set forth in the Agreement, the Provider Manual and any applicable billing manual and claims processing policies.

Definitions:

1. **Allowed Amount** means the amount designated in this Compensation Schedule as the maximum amount payable to a Contracted Provider for any particular Covered Service provided to any particular Covered Person, pursuant to this Agreement or its Attachments.

2. **Allowable Charges** means a Contracted Provider's billed charges for services that qualify as Covered Services.

3. **Cost-Sharing Amounts** means any amounts payable by a Covered Person, such as copayments, cost-sharing, coinsurance, deductibles or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement, if applicable.