Introduced by _____ Council Bill No. _____R 234-13_____

A RESOLUTION

authorizing an ancillary services provider agreement with Home State Health Plan for clinical services.

BE IT RESOLVED BY THE COUNCIL OF THE CITY OF COLUMBIA, MISSOURI, AS FOLLOWS:

SECTION 1. The City Manager is hereby authorized to execute an ancillary services provider agreement with Home State Health Plan. The form and content of the agreement shall be substantially as set forth in "Exhibit A" attached hereto and made a part hereof.

ADOPTED this _____ day of _____, 2013.

ATTEST:

_____ _____

City Clerk Mayor and Presiding Officer

APPROVED AS TO FORM:

_____

City Counselor

ANCILLARY SERVICES PROVIDER AGREEMENT

THIS ANCILLARY SERVICES PROVIDER AGREEMENT ("Agreement") is made and entered into as of the effective date set forth on the signature page below ("Effective Date"), by and between *Columbia/Boone County Dept of Public Health and Human Services ("Provider") and Home State Health Plan, Inc. ("HMO").

* the City of Columbia, Missouri on behalf of its

WHEREAS, Provider is a provider of public health services duly licensed and operating in accordance with all applicable State and federal laws and regulations;

WHEREAS, HMO is in the process of obtaining or has obtained a certificate of authority to operate a health maintenance organization authorized to arrange for the provision of Covered Services to Covered Persons (as hereinafter defined);

WHEREAS, HMO wishes to contract with Provider to provide certain Covered Services to Covered Persons; and

WHEREAS, Provider desires to provide the Covered Services specified in this Agreement to Covered Persons for the consideration, and under the terms and conditions, set forth in this Agreement.

NOW, THEREFORE, in consideration of the premises and mutual promises herein stated, the parties hereby agree as follows:

ARTICLE I
DEFINITIONS

As used in this Agreement and each of its Attachments, each of the following terms (and the plural thereof, when appropriate) shall have the meaning set forth herein.

1.1. ***Affiliate(s)*** means a person or entity controlling, controlled by, or under common control with HMO.

1.2. ***Attachment(s)*** means the attachments to this Agreement, including addenda and exhibits, all of which are hereby incorporated herein by reference, as set forth in Section 11.15 to this Agreement.

1.3. ***Clean Claim*** has, as to each particular product, the meaning set forth in the Attachment pertaining to each such product. If there is no definition for a particular product, "Clean Claim" shall have the meaning set forth in the Provider Manual.

1.4. ***Covered Person*** means a person eligible to receive Covered Services and enrolled in a health benefit plan that is issued or administered by HMO, an Affiliate or Payor.

1.5. ***Covered Services*** means those Medically Necessary health care services covered under the terms of the applicable Payor Contract and rendered in accordance with the Provider Manual.

1.6. ***Emergency or Emergency Care*** has, as to each particular product, the meaning set forth in the Attachment pertaining to each such product. If there is no definition for a particular product, Emergency Care shall mean inpatient and outpatient Covered Services furnished by a qualified provider that are needed to evaluate or stabilize an Emergency Medical Condition.

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

1.8. ***Medical Director*** means a duly licensed physician or his/her physician designee designated by HMO to monitor and evaluate the appropriate utilization of Covered Services by Covered Persons.

1.9. ***Medically Necessary*** means, unless otherwise defined in the applicable Attachment, any health care services determined by HMO's Medical Director or Medical Director's designee to be required to preserve and maintain a Covered Person's health, provided in the most appropriate setting and in a manner consistent with the most appropriate type, level, and length of service, which can be effectively and safely provided to the Covered Person, as determined by acceptable standards of medical practice and not solely for the convenience of the Covered Person, Covered Person's physician, Provider or other health care provider.

1.10. ***Participating Health Care Provider*** means any physician, hospital, ancillary, or other health care provider that has contracted directly or indirectly with HMO to provide Covered Services to Covered Persons and is credentialed in accordance with the HMO's credentialing criteria.

1.11. ***Payor*** means HMO or another entity that is responsible for funding Covered Services to Covered Persons.

1.12. ***Payor Contract*** means HMO's contract with any Payor that governs provision of Covered Services to Covered Persons. Where HMO is the Payor, "Payor Contract" means HMO's contract with the State or federal agency or other entity that has contracted with HMO to arrange for the provision of Covered Services to eligible individuals of such agency or other entity.

1.13. ***Provider Manual*** means the HMO manual of policies, procedures, and requirements to be followed by Participating Health Care Providers. The Provider Manual includes, but is not limited to, utilization management, quality management, grievances and appeals, and Payor-specific program requirements, and may be changed from time to time by HMO.

1.14. ***State*** is defined as the state set forth in the Attachment(s) attached hereto.

ARTICLE II
HMO'S OBLIGATIONS

2.1. Administration. HMO shall be responsible for the administrative activities necessary or required for the commercially reasonable operation of a health maintenance organization. Such activities shall include, but are not limited to, quality improvement, utilization management, grievances and appeals, claims processing, and maintenance of provider directory and records.

2.2. Provider Manual. HMO shall make the Provider Manual available to Provider via HMO's website and upon Provider's request. HMO shall post changes to the Provider Manual on HMO's website or provide Provider with prior written notice of material changes to the Provider Manual.

2.3. Identification Cards. HMO or Payor shall issue to Covered Persons an identification card that shall bear the name of the Covered Person, and a unique identification number.

2.4. Benefits and Eligibility Verification. HMO or Payor, as determined by the Payor Contract, shall be responsible for all eligibility and benefit determinations regarding Covered Services and all communications to Covered Persons regarding final benefit determinations, eligibility, bills, and other matters relating to their status as Covered Persons.

2.5. HMO's Medical Director. HMO shall provide a Medical Director to be responsible for the professional and administrative medical affairs of HMO.

ARTICLE III
PROVIDER'S OBLIGATIONS

3.1. Covered Services. Provider shall provide to Covered Persons those Covered Services described in the applicable Attachment(s) in accordance with the Provider Manual and according to the generally accepted standards of medical practice in the Provider's community, the scope of Provider's license, and the terms and conditions of this Agreement. Provider shall make necessary and appropriate arrangements to assure the availability of Covered Services to Covered Persons during business hours consistent with like providers and in accordance with applicable State and federal law and the Payor Contract.

3.2. Compliance with HMO Policies and Procedures. Provider warrants that Provider and all persons providing services hereunder on Provider's behalf ("Provider Personnel"), shall at all times cooperate and comply with the policies and procedures of Payor, including, but not limited to, the following:

A. HMO's credentialing criteria;

B. HMO's Provider Manual;

C. HMO's medical management program including quality improvement, utilization management, disease management, and case management;

D. HMO's grievance and appeal procedures; and

E. HMO's coordination of benefits and third party liability policies.

3.3. Determination of Covered Person Eligibility. Provider shall verify, in accordance with the Provider Manual, whether an individual seeking Covered Services is a Covered Person. If HMO determines that such individual was not eligible for Covered Services at the time the services were rendered, such services shall not be eligible for payment under this Agreement, and Provider may bill the individual or other responsible entity for such services.

3.4. Emergency Care. Provider shall provide Emergency Care in accordance with applicable federal and State laws and the Payor Contract. Provider shall notify HMO within twenty-four (24) hours or by the next business day of rendering or learning of the rendering of Emergency Care to a Covered Person.

3.5. Acceptance of New Patients. To the extent that Provider is accepting new patients, Provider must also accept new patients who are Covered Persons of HMO. Provider shall provide HMO forty-five (45) days written notice prior to Provider's decision to no longer accept Covered Persons of HMO or any other Payor. In no event shall any established patient of Provider who becomes a Covered Person be considered a new patient.

3.6. Referrals: Reporting to Primary Care Physician. Provider shall provide Covered Services to Covered Persons upon referral from a HMO primary care physician ("PCP") or HMO, and shall arrange for any appropriate referrals and/or admissions of Covered Persons, in accordance with the requirements of the Provider Manual. Provider shall, within a reasonable time following consultation with, or testing of, a Covered Person (not to exceed one (1) week), make a complete written report to the Covered Person's PCP, provided that, with respect to findings which may indicate a need for immediate or urgent follow-up treatment or testing or which may indicate a need for further or follow-up care outside the scope of the referral authorization or outside the scope of Provider's area of expertise, the Provider shall provide an immediate oral report to the Covered Person's PCP, not to exceed twenty-four (24) hours from the time of Provider's consultation or Provider's receipt of the report of the testing, as applicable.

3.7. Preferred Drug List/Drug Formulary. If applicable to the Covered Person's coverage, Provider shall abide by HMO's formulary or preferred drug list when prescribing medications for Covered Persons.

3.8. Treatment Decisions. HMO shall not be liable for, nor will it exercise control over, the manner or method by which Provider provides or arranges for Covered Services. Provider understands that HMO's determinations, if any, to deny payments for services which HMO does not deem to constitute Covered Services or which were not provided in accordance with the requirements of this Agreement, the Attachments or the Provider Manual, are administrative decisions only. Such a denial does not absolve Provider of Provider's responsibility to exercise independent judgment in Covered Person treatment decisions. Nothing in this Agreement is intended to interfere with Provider's provider-patient relationship with Covered Person(s).

3.9. Facilities. Provider agrees that the facilities at which Covered Services are provided hereunder shall be maintained in accordance with all applicable federal and State laws.

3.10. Covered Person Communication. Provider shall obtain Payor and HMO's approval for Covered Person communication as required by the Payor Contract and applicable State and federal law. Nothing in this Agreement shall be construed as limiting Provider's ability to communicate with Covered Persons with regard to quality of health care or medical treatment decisions or alternatives regardless of Covered Service limitations under the Payor Contract.

3.11. Cooperation with HMO Carve-Out Vendors. Provider acknowledges that HMO may, during the term of this Agreement, carve-out certain Covered Services from its general provider contracts, including this Agreement, as HMO deems necessary to promote the quality and cost-effectiveness of services provided to Covered Persons. Provider shall cooperate with any and all third party vendors that have contracted with HMO or an Affiliate of HMO to provide services to Covered Persons.

3.12. Disparagement Prohibition. Provider agrees not to disparage HMO in any manner during the term of this Agreement or in connection with any expiration, termination or non-renewal of this Agreement. Provider shall not interfere with HMO's contractual relationships including, but not limited to, those with other Participating Health Care Providers. Nothing in this provision, however, shall be construed as limiting Provider's ability to inform patients that this Agreement has been terminated or otherwise expired or 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 directed at any specific Covered Person or group of Covered Persons.

3.13. Nondiscrimination. Provider will provide services to Covered Persons without discrimination on account of race, sex, sexual orientation, age, color, religion, national origin, place of residence, health status, type of Payor, source of payment, 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 ("ADA"). Provider recognizes that as a governmental contractor, HMO is subject to various federal laws, executive orders and regulations regarding equal opportunity and affirmative action, which also may be applicable to subcontractors.

3.14. Written Notice. Provider shall give written notice to HMO of: (i) any situation which develops regarding Provider, when notice of that situation has been given to the State agency that licenses Provider, or any other licensing agency or board, or any situation involving an investigation or complaint filed by the State agency that licenses Provider, or any other licensing agency or board, regarding a complaint against Provider's license; (ii) when a change in Provider's license to practice medicine is affected or any form of reportable discipline is taken against such license; (iii) suspension or exclusion under a federal health care program, including, but not limited to, Medicaid; (iv) any government agency request for access to records; or (v) any lawsuit or claim filed or asserted against Provider alleging professional malpractice, regardless of whether the lawsuit or claim involves a Covered Person. In any such instance described above, Provider must notify HMO in writing within ten (10) days from the date Provider first receives notice, whether written or oral, with the exception of those lawsuits or claims which do not involve a Covered Person, with respect to which Provider has thirty (30) days to notify HMO.

3.15. Use of Name. Provider agrees that HMO may use Provider's name, address, phone number, type of practice, and an indication of Provider's willingness to accept additional Covered Persons in HMO's roster of Participating Health Care Providers and marketing materials.

ARTICLE IV
COMPLIANCE WITH LAW

4.1. Compliance with Law and Payor Contracts. Provider and HMO agree that each party shall carry out its obligations in accordance with terms of the Payor Contract and applicable federal and State laws and regulations, including, but not limited to, the requirements of the Stark law (42 U.S.C. § 1395nn) and applicable federal and State self-referral and fraud and abuse statutes and regulations. If, due to Provider's noncompliance with law, the Payor Contract or this Agreement, sanctions or penalties are imposed on HMO, HMO may, in its sole discretion, offset sanction or penalty amounts against any amounts due Provider from HMO or require Provider to reimburse HMO for the amount of any such sanction or penalty.

4.2. HIPAA Compliance. Provider and HMO shall abide by the administrative simplification provisions of the Health Insurance Portability and Accountability Act ("HIPAA"), its implementing regulations [45 C.F.R. parts 160 and 164] and all other federal and State laws regarding confidentiality and disclosure of medical records and other health and Covered Person information, including safeguarding the privacy and confidentiality of any protected health information ("PHI") that identifies a particular Covered Person. Provider shall assure its own compliance and that of its business associates with HIPAA.

ARTICLE V
CLAIMS SUBMISSION, PROCESSING, AND COMPENSATION

5.1. Claims or Encounter Submission. Provider shall submit to Payor claims or encounters for Covered Services within one hundred eighty (180) days from the date of service. Payor reserves the right to deny payment to Provider if Provider fails to submit in accordance with the Provider Manual. If applicable, based on Provider's compensation arrangement, Provider shall submit encounter data to Payor in a timely fashion, which shall contain such statistical and descriptive medical and patient data and identifying information as specified in the Provider Manual.

5.2. Compensation. Payor shall pay Clean Claims from Provider for Covered Services provided to Covered Persons in accordance with the applicable exhibit less any applicable copayments, cost-sharing or other amounts that are the Covered Person's financial responsibility. Provider agrees to accept such payments as payment in full for such Covered Services.

5.3. Financial Incentives. Nothing in this Agreement shall, or shall be construed to, create any financial incentive for Provider to withhold Medically Necessary services.

5.4. Covered Person Hold Harmless. Provider agrees that in no event including, but not limited to, non-payment by HMO, HMO 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 Covered Person for Covered Services provided pursuant to this Agreement. This provision shall not prohibit collection of any applicable copayments or other amounts that are the Covered Person's financial responsibility. This provision shall survive termination or expiration of this Agreement for any reason, shall be construed for the benefit of Covered Persons, and supersedes any oral or written agreement entered into between the Provider and a Covered Person.

5.5. Recoupment Rights. Payor shall have the right to immediately recoup any and all amounts owed by Provider to Payor or any Affiliate against amounts owed by Payor or Affiliate to Provider. Provider agrees that all recoupment and any offset rights under this Agreement shall constitute rights of recoupment authorized under State or federal law and that such rights shall 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.

ARTICLE VI
RECORDS/INSPECTIONS

6.1. Medical Records/Advance Directives. Provider shall maintain a complete and accurate permanent medical record for each Covered Person to whom Provider renders services under this Agreement and shall include in that record all reports from Participating Health Care Providers and all documentation required by applicable law, regulations, professional standards and the Provider Manual. Provider shall document in the Covered

Person's medical record whether the Covered Person has executed an advance directive and agrees to comply with all federal and State laws regarding advance directives. Medical records of Covered Persons shall be treated as confidential so as to comply with all federal and State laws and regulations regarding the confidentiality of the patient records.

6.2. Records. Provider shall maintain records related to services provided to Covered Persons and provide such medical, financial and administrative information to HMO and State and federal government agencies as may be necessary for compliance by HMO with State and federal law and accreditation standards, as well as for the administration of this Agreement. HMO shall have access at reasonable times to books, records, and papers of the Provider relating to the health care services provided to Covered Persons for Covered Services.

6.3. Consent to Release Medical Records. Provider shall obtain Covered Person authorizations relative to the release of medical information required by applicable law to provide HMO or other authorized parties with access to Covered Persons' records.

6.4. Access. In accordance with applicable law, Provider shall provide access to Provider's records to the following, including any designee or duly authorized agent:

A. Payors, during regular business hours and upon prior notice;

B. government agencies, to the extent such access is necessary to comply with regulatory requirements that apply to HMO or Payors; and

C. accreditation agencies.

Provider shall provide copies of records at no expense.

6.5. Record Transfer. Subject to applicable law and Payor Contract requirements, Provider shall cooperate in the timely transfer of Covered Persons' medical records to any other health care provider at no charge and when required.

6.6. On-Site Inspections. Provider agrees that medical office space or its facilities, as applicable, shall be maintained in accordance with applicable federal and State regulatory requirements. Provider shall cooperate in on-site inspections of medical office space by HMO, authorized government officials, and accreditation bodies. Provider shall compile any and all information in a timely manner required to evidence Provider's compliance with this Agreement, as requested by such agency(ies), or as otherwise necessary for the expeditious completion of such on-site inspection.

ARTICLE VII
INSURANCE

7.1. Provider Insurance. During the term of this Agreement, Provider shall maintain policies of general and professional liability insurance and other insurance that are necessary to insure Provider, and any other person providing services hereunder on Provider's behalf, against any claim(s) of personal injuries or death alleged or caused by Provider's performance under this Agreement. Such insurance shall include, but not be limited to, tail or prior acts coverage necessary to avoid any gap in coverage. Insurance shall be through a licensed carrier, and in a minimum amount of one million dollars ($1,000,000) per occurrence, and have an annual aggregate of no less than three million dollars ($3,000,000) unless a lesser amount is accepted by HMO or where State law mandates otherwise. Provider will provide HMO with at least fifteen (15) days notice of such cancellation, non-renewal, lapse, or adverse material modification of coverage. Upon HMO's request, Provider will furnish HMO with evidence of such insurance.

7.2. Other Insurance. All parties to this Agreement shall maintain in full force and effect appropriate workers' compensation protection and unemployment insurance as required by law.

ARTICLE VIII
INDEMNIFICATION

8.1. HMO Indemnification. Provider agrees to indemnify and hold harmless (and at HMO's request defend) HMO, its Affiliates, officers, employees and agents from and against any and all claims, loss, damages, liability, costs, expenses (including reasonable attorney's fees), judgments, or obligations arising from or in connection with third party claims alleging any negligence or otherwise wrongful act or omissions of Provider, its agents or employees in the performance of Provider's obligations under this Agreement.

8.2. Provider Indemnification. HMO agrees to indemnify and hold harmless (and at Provider's request defend) Provider, its officers, employees and agents from and against any and all claims, loss, damages, liability, costs, expenses (including reasonable attorney's fees), judgments, or obligations arising from or in connection with third party claims alleging any negligence or otherwise wrongful act or omission of HMO, its agents or employees in the performance of HMO's obligations under this Agreement.

8.3 Nothing contained herein shall be deemed a waiver of Providers Sovereign immunity under State law.

ARTICLE IX
DISPUTE RESOLUTION

9.1. Informal Dispute Resolution. Any disputes between the parties arising with respect to the performance or interpretation of this Agreement ("Dispute") shall first be resolved by exhausting the processes available in the Provider Manual, then through good faith negotiations between designated representatives of the parties that have authority to settle the Dispute. If the matter has not been resolved within sixty (60) days of the request for

negotiation, either party may initiate arbitration in accordance with the Arbitration section of this Agreement by providing written notice to the other party.

9.2. Arbitration. If a Dispute is not resolved in accordance with the Informal Dispute Resolution section of this Agreement, either party wishing to pursue the Dispute shall submit it to binding arbitration conducted in accordance with the Commercial Arbitration Rules of the American Arbitration Association ("AAA"). In no event may any arbitration be initiated more than one (1) year following the end of the sixty (60) day negotiation period of the Informal Dispute Resolution section of this Agreement. Arbitration proceedings shall be conducted at a mutually agreed upon location within the State. The arbitrators shall have no right to award any punitive or exemplary damages or to vary or ignore the terms of this Agreement and shall be bound by controlling law. Each party shall bear its own costs related to the arbitration except that the costs imposed by the AAA shall be shared equally. The existence of a Dispute or arbitration proceeding shall not in and of itself constitute cause for termination of this Agreement. During an arbitration proceeding, each party shall continue to perform its obligations under this Agreement pending the decision of the arbitrator.

ARTICLE X
TERM AND TERMINATION

10.1. Term. This Agreement shall have an initial term of three (3) year(s), commencing on the Effective Date and remaining in effect unless sooner terminated as provided in this Agreement. After the expiration of the initial term, this Agreement shall automatically renew for terms of one (1) year each, 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 renewal date. Notwithstanding the foregoing, this Agreement may terminate in accordance with the Termination sections below.

10.2. Termination of Agreement. This Agreement may be terminated under any of the following circumstances:

A. By either party upon one hundred eighty (180) days prior written notice effective at the end of the initial term or at the end of any renewal term;

B. By either party upon ninety (90) days prior written notice if the other party is in material breach of this Agreement, except that such termination shall not take place if the breach is cured within sixty (60) days following the written notice;

C. Immediately upon written notice by HMO if there is imminent harm to patient health or fraud or malfeasance is suspected;

D. Immediately upon written notice by either party if the other party becomes insolvent or has bankruptcy proceedings initiated against it;

E. Immediately upon written notice by Provider if HMO loses, relinquishes, or has materially affected its certificate of authority to operate as a health maintenance organization; or

F. Immediately upon written notice by HMO if Provider fails to adhere to HMO's credentialing criteria, including, but not limited to, if Provider (1) loses, relinquishes, or has materially affected its license to provide Covered Services in the State, (2) fails to comply with the insurance requirements set forth in this Agreement; or (3) is convicted of a criminal offense related to involvement in any Medicare or Medicaid program or has been terminated, suspended, barred, voluntarily withdrawn as part of a settlement agreement, or otherwise excluded from any Medicare or Medicaid program.

10.3. Rights and Obligations Upon Termination. Upon termination, the rights of each party hereunder shall terminate, provided, however, that such action shall not release the Provider or HMO of their obligations with respect to: (a) payments accrued to Provider prior to termination; (b) Provider's agreement not to seek compensation from Covered Persons for Covered Services prior to termination; and (c) completion of treatment of Covered Persons who are receiving care until continuation of the Covered Person's care can be arranged by HMO as determined by the Medical Director or as required by applicable law or the Payor Contract. Services provided during continuation of care shall be reimbursed in accordance with the terms of this Agreement.

10.4. Survival of Obligations. Any obligations that cannot be fully performed prior to the termination of this Agreement including, but not limited to, obligations in the following provisions set forth in this Section, shall survive the termination of this Agreement: Section 3.12 (Disparagement Prohibition); Article IV (Compliance With Law); Section 5.4 (Covered Person Hold Harmless); Article VI (Records/Inspection); Article VII (Insurance); Article VIII (Indemnification); Article IX (Dispute Resolution); Section 10.3 (Rights and Obligations Upon Termination).

ARTICLE XI
MISCELLANEOUS

11.1. Relationship of Parties. The relationship among the parties is that of independent contractors. None of the provisions of this Agreement are intended to create, or to be construed as creating, any agency, partnership, joint venture, employee-employer, or other relationship.

11.2. Conflicts Between Certain Documents. If there is any conflict between this Agreement hereto and the Provider Manual, this Agreement shall control. In the event of any conflict, however, between this Agreement and any Attachment hereto, the Attachment shall be controlling as to the product described in that Attachment. In the event of any conflicts between this Agreement, or any Attachment hereto, and the applicable Payor Contract with respect to what services constitute Covered Services, the Payor Contract shall control.

11.3. Assignment; Delegation of Duties. This Agreement is intended to secure the services of and be personal to Provider, and shall not be assigned, sublet, delegated or transferred by Provider without the prior written consent of HMO.

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

11.5. Governing Law. All matters affecting the interpretation of this Agreement and the rights and obligations of the parties hereto shall be governed by and construed in accordance with applicable federal and State laws.

11.6. Third Party Beneficiary. Except as specifically provided herein, the terms and conditions of this Agreement shall be for the sole and exclusive benefit of Provider and HMO. Nothing herein, express or implied, is intended to be construed or deemed to create any rights or remedies in any third party.

11.7. Amendment. This Agreement, including all Attachments, may be amended at any time by mutual written agreement of the parties. This Agreement and any of its Attachments may also be amended by HMO furnishing Provider with any proposed amendments. Unless Provider objects in writing to such amendment during the thirty (30) day notice, Provider shall be deemed to have accepted the amendment. Notwithstanding the foregoing, this Agreement shall be automatically amended as necessary to comply with any applicable State or federal law or regulation and applicable provision of the Payor Contract.

11.8. Entire Agreement. This Agreement, its Attachments, and the Provider Manual contain all the terms and conditions agreed upon by the parties and supersede all other agreements, oral or otherwise, of the parties hereto, regarding the subject matter of this Agreement.

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

11.10. Waiver. The waiver by either party of the violation of any provision or obligation of this Agreement shall not constitute the waiver of any subsequent violation of the same or other provision or obligation.

11.11. Notices. Any notice required to be given pursuant to the terms and provisions hereof shall be in writing and shall be sent by certified mail, return receipt requested, postage prepaid, or by recognized courier service, addressed as follows:

To HMO at:	To Provider at:
Attn: President	Attn: Michelle Lewis
Home State Health Plan, Inc.	Columbia/Boone County Dept of Public Health and Human Services
7700 Forsyth Blvd.	1005 W. Worley St
St. Louis, MO 63105	Columbia, MO 65203

or to such other address as either party may designate in writing.

11.12. 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.

11.13. Confidentiality. Neither party shall disclose the substance of this Agreement nor any information acquired from the other party during the course of or pursuant to this Agreement to any third party, unless required by law. Provider acknowledges and agrees that all information relating to HMO's programs, policies, protocols and procedures is proprietary information and further agrees not to disclose such information to any person or entity without HMO's express written consent.

11.14. Authority. The parties whose signatures are set forth below represent and warrant that they are duly empowered to execute this Agreement.

11.15. Attachments. Each of the Attachments below is hereby made part of this Agreement:

Attachment A – State Mandated Provisions
Attachment B – Product Attachment
Exhibit 1 – Ancillary Compensation Schedule

[SIGNATURE BLOCK FOLLOWS]

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

THIS AGREEMENT MAY BE SUBJECT TO APPROVAL BY THE DEPARTMENT OF INSURANCE.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement effective as of the date set forth below.

HMO:	**Provider:**
Home State Health Plan, Inc.	City of Columbia, on behalf of its **Columbia/Boone County Dept of Public Health and Human Services**
Authorized Signature	Authorized Signature
Printed Name:	Printed Name:
Title:	Title:
Signature Date:	Signature Date:
Effective Date of Agreement: (To be completed by HMO only)	Tax Identification Number: 43-600810
	National Provider Identifier: 1144207960
	State Medicaid Number:

To be completed by HMO only:

Effective Date of Agreement:

ATTACHMENT A

STATE-MANDATED PROVISIONS

This Attachment A, State-Mandated Provisions, ("Attachment A") is incorporated into the Ancillary Services Provider Agreement ("Agreement") entered into by and between Columbia/Boone County Dept of Public Health and Human Services ("Provider") and Home State Health Plan, Inc. ("HMO") as of the Effective Date. HMO and Provider shall comply with the following provisions, which are required by State law to be included in this Agreement, to the extent applicable and as such, provisions 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 or any other Attachments, 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.

   (a) Contracted Provider means Provider and any licensed health care professional or facility on whose behalf Provider is authorized to negotiate and execute provider contracts with HMO, and who participates under the Agreement as a Participating Health Care Provider.

   (b) "Intermediary" has the meaning given such term in Missouri Revised Statute §354.600(13), which as of the Effective Date, means a person authorized to negotiate and execute provider contracts with HMO on behalf of health care providers or on behalf of a network.

   (c) "State" means the State of Missouri.

2. HMO Limitations. Neither HMO nor any Intermediary shall restrict Contracted Provider from discussing or disclosing to any Covered Person any information that Contracted Provider deems appropriate regarding the nature of treatment, risks or alternatives thereto, the availability of other therapy, consultation or test, the decision of any HMO to authorize or deny services, or the process that HMO or any person contracting with HMO uses or proposes to use to authorize or deny health care services or benefits.

3. Hold Harmless. Contracted Provider agrees that in no event, including but not limited to nonpayment by HMO or any Intermediary, insolvency of HMO or any Intermediary, or breach of this Agreement, shall the Contracted Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Covered Person or other person, other than HMO or the applicable Intermediary, if any, acting on behalf of the Covered Person for services provided pursuant to this Agreement. This Agreement does not prohibit the Contracted Provider from collecting coinsurance, deductibles or co-payments, as specifically provided in the Payor Contract, or fees for non-covered services delivered on a fee-for-service basis to Covered Persons. This Agreement does not prohibit Contracted Provider, except for a health care professional who is employed

full time on the staff of HMO and has agreed to provide service exclusively to HMO's Covered Persons and no others, and a Covered Person from agreeing to continue services solely at the expense of the Covered Person, as long as Contracted Provider has clearly informed the Covered Persons that HMO may not cover or continue to cover a specific service or services. Except as provided herein, this Agreement does not prohibit Contracted Provider from pursuing any available legal remedy, including, but not limited to, collecting from any insurance carrier providing coverage to a Covered Person. This provision survives the termination of the Agreement regardless of the reason for termination.

4. Continuation of Services. In the event of HMO's or Intermediary's insolvency or other cessation of operations, Contracted Provider shall continue to provide Covered Services to Covered Persons through the period for which premium has been paid to HMO on behalf of the Covered Person or until the Covered Person's discharge from an inpatient facility, whichever time is greater.

5. Non-Discrimination. Contracted Provider shall accept Covered Persons for treatment and shall not intentionally segregate Covered Persons in any way from other persons receiving services. Contracted Provider shall provide Covered Services without regard to race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual preference, health status, status as a private purchaser or as a participant in a publicly financed program income status, program membership, or physical or behavioral disability, except where medically indicated.

6. Notice of Termination; List of Covered Persons. The parties agree that any notice of termination given by either party must state the reason for the termination. Within fifteen (15) business days of the date that Contracted Provider either gives or receives notice of termination of the Agreement, Contracted Provider shall supply HMO with a list of all Covered Persons who are patients of Contracted Provider.

7. Continue Care upon Termination. After the effective date of termination of the Agreement, the Agreement and its Attachments (including this Attachment A) will remain in effect for purposes of those obligations and rights arising prior to the effective date of termination. Upon termination of the Agreement, Contracted Provider shall (i) continue to provide Covered Services to Covered Persons during the longer of the ninety (90) day period following the date of termination of the Agreement or such other period as may be required by laws, regulations, standards or requirements applicable to HMO, and, if requested by HMO shall continue to provide Covered Services to Covered Persons until such Covered Persons are assigned or transferred to another HMO Participating Health Care Provider, and (ii) continue to comply with and abide by all of the terms and conditions of the Agreement and this Attachment A, including, but not limited to, Section 3.27 above, in connection with the provision of such Covered Services during such continuation period. During the continuation period, Contracted Provider shall be compensated in accordance with the Agreement for Covered Services rendered to a Covered Person after termination of the Agreement and shall accept such compensation as payment in full. This provision survives the termination of this Agreement.

8. Compel to Furnish Records. As required by the Agreement, Contracted Provider shall furnish to HMO all documentation required by HMO to monitor, on an ongoing basis, the ability, clinical capacity, and legal authority of Contracted Provider to provide all Covered Services to Covered Persons.

9. Access to Entire Network. Neither party shall act in a manner that unreasonably restricts a Covered Person's access to HMO's entire provider network, unless otherwise provided in or contemplated by the Payor Contract.

10. Provider Notification. In accordance with the Agreement, Contracted Provider acknowledges that it will be notified of HMO's administrative procedures, and on an ongoing basis of specific Covered Services for which Contracted Provider is responsible, including limitations or conditions on services. Contracted Provider is responsible for collecting applicable coinsurance, co-payments and deductibles, if any, from Covered Persons.

11. Provider Notification of Termination. When expressly required by applicable law or otherwise deemed appropriate by HMO, and if timely requested by Provider, HMO will provide Provider with an opportunity for a review or hearing as required by law and in accordance with HMO's applicable procedures. For purposes of this Section 11 only, a "termination" of the Agreement is different than a "non-renewal" of the Agreement.

12. 30 Day Review of Contract. Contracted Provider hereby acknowledges that Contracted Provider was allowed at least thirty (30) days to review the Agreement and this Attachment A prior to Provider's execution.

13. Intermediaries. If Provider is an Intermediary, the provisions set forth below apply.

    (a) Provider shall, and shall require each other Contracted Provider to, comply with the Agreement and its Attachments (including this Attachment A), and applicable law, including but not limited to Sections 354.600 to 354.636 of the Missouri Revised Statutes, as amended.

    (b) If required by HMO, Provider shall transmit utilization documentation and claims paid documentation to the HMO.

    (c) Provider shall maintain the books, records, financial information and documentation of services provided to Covered Persons at its principal place of business within the State and preserve them for five (5) years in a manner that facilitates regulatory review.

    (d) Provider shall allow HMO and regulatory authorities access to the books, records, financial information and any documentation of services provided to Covered Persons, as necessary to determine compliance with Sections 354.600 to 354.636 of the Missouri Revised Statutes, as amended.

    (e) Provider agrees that HMO has the right, in the event of the Provider's insolvency, to require assignment to HMO of the provisions of a Contracted Provider's contract with Provider addressing the Contracting Provider's obligation to furnish Covered Services.

ATTACHMENT B
MO HEALTHNET MANAGED CARE – MEDICAID PRODUCT ATTACHMENT

This MO HealthNet Managed Care Medicaid Product Attachment (the ***"Product Attachment"***) is incorporated into the Ancillary Services Provider Agreement (the ***"Agreement"***) entered into by and between Columbia/Boone County Dept of Public Health and Human Services (in this Product Attachment referred to as ***"Provider"***) and Home State Health Plan, Inc. ("HMO") as of the Effective Date.

ARTICLE I
MO HEALTHNET MEDICAID PROGRAM COMPLIANCE

1.1 HMO has contracted with the State of Missouri Department of Social Services, MO HealthNet Division (***"MO HealthNet"***) to arrange for the provision of medical services to Covered Persons under the MO HealthNet Managed Care Medicaid program (***"MO HealthNet Medicaid Program"***).

1.2 Provider has entered into the Agreement with HMO to provide Covered Services to Covered Persons. This Attachment is intended to supplement the Agreement by setting forth the parties' rights and responsibilities related to the provision of Covered Services to Covered Persons as pertaining to the MO HealthNet Medicaid Program. In the event of a conflict between the terms and conditions of the Agreement and the terms and conditions of this Product Attachment, this Product Attachment shall govern.

1.3 Notwithstanding any provisions set forth in this Attachment, to the extent applicable, Provider shall comply with all duties and obligations under the Agreement, HMO's Provider Manual and this Product Attachment. Provider agrees and understands that Covered Services shall be provided in accordance with the contract between the MO HealthNet and HMO (***"State Contract"***), this Product Attachment, the Agreement, HMO's Provider Manual, any applicable State Medicaid Program Provider Manuals and Handbooks, and all applicable State and federal laws and regulations. To the extent Provider is unclear about Provider's duties and obligations, Provider shall request clarification from HMO.

ARTICLE II
DEFINITIONS

For purposes of this Product Attachment and the Agreement, the following terms shall be defined as set forth below, and the definitions listed below will supersede any different meanings contained in the Agreement. Capitalized terms used in this Product Attachment and not defined below shall have the same meaning set forth in the Agreement.

2.1 ***Clean Claim*** shall mean a claim that has no defect, impropriety, lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment.

2.2 ***Covered Person*** shall have the meaning set forth in the Agreement.

2.3 ***Emergency Medical/Behavioral Health/Substance Abuse Services*** shall mean covered inpatient and outpatient services that are: (1) furnished by a provider qualified to furnish these services and (2) needed to evaluate or stabilize an Emergency Medical Condition.

2.4 ***Emergency Medical Condition*** means a medical, behavioral health, or substance use-related condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonable expect the absence of immediate medical attention to result in the following:

A. Placing the physical or behavioral health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

B. Serious impairment to bodily functions;

C. Serious dysfunction of any bodily organ or part;

D. Serious harm to self or others due to an alcohol or drug abuse emergency;

E. Injury to self or bodily harm to others; or

F. With respect to a pregnant woman having contractions: (1) that there is inadequate time to effect a safe transfer to another hospital before delivery, or (2) that transfer may pose a threat to the health or safety of the woman or the unborn.

2.5 ***Medically Necessary*** shall mean the provision of Covered Services sufficient in amount, duration, and scope to reasonably achieve their purpose, and in accordance with accepted standards of practice in the medical community of the area in which the services are rendered. Services shall be furnished in the most appropriate setting. Services may be limited by medical necessity. A service shall be considered medically necessary if it (1) prevents, diagnoses, or treats a physical or behavioral health or injury; (2) is necessary for the Covered Person to achieve age appropriate growth and development; (3) minimizes the progression of disability; or (4) is necessary for the Covered Person to attain, maintain, or regain functional capacity. A service shall not be considered reasonable and medically necessary if it can be omitted without adversely affecting the Covered Person's condition or the quality of medical care rendered.

2.6 ***Primary Care Provider or PCP*** shall mean licensed physicians specializing in family and general practice, pediatrics, obstetrics/gynecology (OB/GYN), and internal medicine; registered nurses who are advanced practice nurses with specialties in family practice, pediatric practice, behavioral health, and OB/GYN practice.

2.7 ***State Agency*** shall mean the Department of Social Services, MO HealthNet Division.

2.8 ***State*** shall mean the State of Missouri.

ARTICLE III
PROVIDER CONTRACT REQUIREMENTS

3.1 Provider shall comply with all provisions of the State Contract federal, State and local laws and regulations, and all amendments thereto. Provider understands and agrees that this Product Attachment and/or this Agreement shall be deemed automatically amended as necessary to comply with any applicable State or federal or regulation, or any applicable provision of the State Contract.

3.2 Provider shall comply with all federal and State statutes, regulations, as amended, and polices and executive orders relating to nondiscrimination and equal employment opportunity to the extent applicable to this Agreement.

3.3 Provider shall ensure that all Covered Persons receive equitable and effective treatment in a culturally and linguistically appropriate manner. Provider shall provide effective, understandable, and respectful care that is provided in a manner compatible with the Covered Persons cultural health beliefs and practices and preferred language.

3.4 If Provider is a PCP, Provider's responsibilities shall include the following in addition to the other obligations set forth in this Agreement:

A. Serve as the Covered Person's initial and most important contact;

B. Maintain continuity of each Covered Person's health care;

C. Make referrals for specialty care and other Medically Necessary services to both in-network and out-of-network providers;

D. Collaborate with HMO case managers to develop plans of care for Covered Persons receive case management services;

E. Conduct a behavioral health screen to determine whether the Covered Person needs Behavioral Health Services; and

F. Maintain a comprehensive current medical record for the Covered Person, including documentation of all services provided to the Covered Person by the PCP, as well as any specialty or referral services, diagnostic reports, physical and behavioral health screens, etc.

3.5 If applicable, Provider shall either be available, or arrange for another Participating Health Care Provider to be available to perform Emergency Medical/ Behavioral Health Services on a twenty-four (24) hours, seven (7) days per week in order to treat an Emergency Medical Condition.

3.6 Provider shall meet the following appointment wait time standards:

3.6.1 Provider shall ensure that waiting times (defined as time spent both in the lobby and in the examination room prior to being seen by a Provider) for appointments do not exceed one (1) hour from the scheduled appointment time;

3.6.2 Provider shall ensure that the time elapsed between the request for appointments and the scheduled appointments do not exceed the following:

i. Twenty four (24) hours for urgent care appointments for illness injuries which require care immediately but do not constitute emergencies (e.g. high temperature, persistent vomiting or diarrhea, symptoms which are of sudden or severe onset but which do not require emergency room services);

ii. Within one (1) week or five (5) business days, whichever is earlier for routine care with symptoms (e.g., persistent rash, recurring high grade temperature nonspecific pain, fever);

iii. Within thirty (30) calendar days for routine care without symptoms (e.g. well child exams, routine physical exams);

iv. Within seven (7) calendar days after hospital discharge for behavioral health and Substance abuse services.

3.6.3 For maternity care, Provider shall provide initial prenatal care appointments for enrolled pregnant Covered Persons as follows:

i. First trimester appointments must be available within seven (7) calendar days of first request;

ii. Second trimester appointments must be available within seven (7) calendar days of first request;

iii. Third trimester appointments must be available within three (3) calendar days of first request; and

iv. Appointments for high risk pregnancies must be available within three (3) calendar days of identification of high risk.

3.7 Provider shall maintain an adequate and complete medical record for each Covered Person and may maintain electronic records provided the record keeping form is capable of being printed for review in accordance with RSMo §334.097. An adequate and complete medical record shall include documentation of the following information:

A. Identification of the Covered Person, including name, birth date, address and telephone number;

B. The date(s) the Covered Person was seen;

C. The current status of the Covered Person, including the reason for the visit;

D. Observation of pertinent physical findings;

E. Assessment and clinical impression of diagnosis;

F. Plan for care and treatment, or additional consultation or diagnostic testing, if necessary. If treatment includes medication, the Provider shall include in the medical record the medication and dosage of any medication prescribed, dispensed, or administered; and

G. Any informed consent for office procedures.

3.8 Provider shall maintain all medical records remaining under the care, custody, and control of the Provider, or the Provider's designee, for a minimum of seven (7) years from the date of when the last professional service was provided.

3.9 Provider shall not knowingly employ, hire for employment or continue to employ an unauthorized alien to perform work within the State.

3.10 If Provider is an FQHC or RHC, Provider shall be reimbursed by the State at one hundred percent (100%) of its reasonable cost for Covered Services.

3.11 If Provider is a hospital, Provider shall notify the HMO and the Family Support Division of births where the mother is a Covered Person.

3.12 Provider shall not be restricted from advising or advocating on behalf of a Covered Person who is his or her patient:

A. For the Covered Person's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

B. For any information the Covered Person needs in order to decide among all relevant treatment options;

C. For the risks, benefits and consequences of treatment or non-treatment; and

D. For the Covered Person's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions; and

3.13 Provider shall not conduct or participate in HMO enrollment, disenrollment, transfer, or opt out activities. Provider shall not influence a Covered Person's enrollment.

3.14 In the event of HMO's insolvency or other cessation of operations, Provider shall continue to provide Covered Services to Covered Persons through the period for which a capitation payment has been made to HMO or until the Covered Person's discharge from an inpatient facility, whichever time is greater.

3.15 Provider acknowledges and agrees that HMO may revoke the Agreement or impose other sanctions if the Provider's performance is inadequate.

3.16 Provider shall comply with the consumer protection provisions outlined in Section 2.13.1 of the State Contract.

3.17 Provider shall provide Covered Person with one (1) free copy of his or her medical records annually. The fee for additional copies shall not exceed the actual cost of time and materials used to compile, copy, and furnish such records.

3.18 Provider shall comply with all fraud and abuse provisions outlined in the State Contract.

3.19 Provider shall, using the databases outlined in Section 3.8.6(u) of the State Contract, screen all employees to determine whether any of them (i) have been excluded from Medicaid, Medicare, CHIP or any other Federal health care programs, (ii) have failed to renew their license or certification registration, (iii) has a revoked professional license or certification, or (iv) has been terminated by the Missouri Department of Social Services. Provider shall not employ or contract with any individual or entity identified by an initial screening and shall terminate any current employee or subcontractor identified in a monthly screening.

3.20 Provider shall provide all Covered Services under the Agreement within the United States.

3.21 Provider shall comply with the Pro-Children Act of 1994 (20 U.S.C. 6081) ("Act"), which prohibits smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

3.22 Provider shall comply with all applicable standards, orders or regulations issued pursuant to the Clean Air Act (42 U.S.C. 7401 et seq.) and the Federal Water Pollution Control Act, as amended (33 U.S.C. 1251 et seq.).

3.23 Provider shall comply with all federal and State statutes, regulations and executive orders relating to nondiscrimination and equal employment opportunity to the extent applicable to the State Contract.

3.24 Provider shall have a national provider identifier (NPI), and shall include the NPI on each claim for payment for services submitted to HMO with dates of service beginning January 1, 2013.

3.25 Provider shall accept Covered Persons for treatment and shall not intentionally segregate Covered Persons in any way from other persons receiving services. Provider shall provide Covered Services without regard to race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual preference, health status, status as a private purchaser or as a participant in a publicly financed program income status, program membership, or physical or behavioral disability, except where medically indicated.

3.26 If Provider is a behavioral health or substance abuse provider, Provider shall complete a health status screen, at the initial point of contact and as part of the re-assessment process for Covered Persons in treatment, and Provider shall refer Covered Persons with physical health conditions (as indicated by the screen) to their Primary Care Provider for evaluation and treatment of the physical health condition.

3.27 Provider shall hold each Covered Person harmless for the costs of Covered Services except for applicable cost sharing amounts under the MO HealthNet Medicaid Program.

3.28 When a service to be provided by Provider for a Covered Person is not in the comprehensive benefit package that is part of the MO HealthNet Medicaid Program, then prior to providing the service, Provider shall inform the Covered Person that the service is not covered. If the Covered Person still requests the service, the Provider shall obtain the Covered Person's acknowledgement that the service is not covered in writing (private pay agreement) prior to rendering the service. Regardless of any understanding worked out between Provider and Covered Person about private payment, if Provider bills HMO for the non-Covered Service that has been provided, Provider agrees that the prior arrangement with the Covered Person becomes null and void.

3.29 Subject to the right of a parent or guardian of a child to elect not to have screening, if Provider is a physician, Provider shall perform early and periodic screening, diagnostic, and treatment services in accordance with Omnibus Budget Reconciliation Act of 1989 for all eligible Covered Persons under the age of twenty-one (21) to identify health and developmental problems.

3.30 If Provider is a Primary Care Physician, Provider shall coordinate Medically Necessary inpatient days for behavioral health and substance abuse services (billable on an inpatient

hospital claim form) beyond the days deemed Medically Necessary for the physical health of a Covered Person under the age of twenty-one (21) with the Covered Person's caseworker.

3.31 A Covered Person shall not be held liable for any the following: (a) services provided to the Covered Person by Provider, or another health care provider with a contractual, referral, or other arrangement with Provider, in the event payment is not received for such services; or (b) payments due to Provider, or another health care provider under a contractual, referral, or other arrangement with Provider, for furnishing Covered Services in excess of the amount that would be owed by the Covered Person if HMO had directly provided the services.

3.32 Provider shall maintain medical records in a detailed and comprehensive manner which conforms to good professional medical practice, permits effective professional medical review and medical audit processes, and facilitates an adequate system for follow- up treatment. Provider shall ensure that medical records are legible, signed and dated. When a Covered Person changes Primary Care Providers, upon request, his or her Provider shall forward medical records or copies of medical records to the new Primary Care Provider within ten (10) business days from receipt of request or prior to the next scheduled appointment to the new Primary Care Provider whichever is earlier. Provider agrees that neither the State Agency nor HMO is required to obtain written approval from a Covered Person before requesting the Covered Person's record from Provider. If the State Agency requests, or if HMO requests pursuant to a State Agency request, Provider shall provide the requesting person with all medical records for the designated Covered Persons.

3.33 Provider shall immediately notify HMO if Provider is sanctioned by the Office of Inspector General (OIG), fails to renew a license or certification registration, has a professional license or certification revoked, or is terminated by the State Agency, and Provider agrees that Provider's participation under the Agreement will immediately cease upon the occurrence of any of the aforesaid events. Provider also agrees that Provider will not receive any payment for any items or services that Provider furnished, directed or prescribed if at the time Provider furnished, directed or prescribed such items or services, Provider was excluded from participation in a federal health care program by the OIG of the U.S. Department of Health and Human Services under either Section 1128 or 1128A of the Social Security Act, except as permitted under 42 CFR 1001.1801 and 1001.1901.

3.34 Within ten (10) days of a written request from HMO, Provider shall disclose to HMO full and complete information regarding ownership, financial transactions, and persons convicted of criminal activity related to Medicare, Medicaid, or the Federal Title XX programs in accordance with federal and State requirements, including Public Chapter 379 of the Acts of 1999 and 42 CFR 455.104-106 and 42 CFR 1001.1001-1051, applicable to HMO.

EXHIBIT 1
ANCILLARY COMPENSATION SCHEDULE – MEDICAID

COLUMBIA/BOONE COUNTY DEPT OF PUBLIC HEALTH AND HUMAN SERVICES

For Covered Services provided to Covered Persons, Payor shall pay Provider the lesser of: (i) the Provider's Allowable Charges; or (ii) one hundred percent (100%) of the current State Medicaid fee schedule in effect on the date of service and specific to the services rendered.

Additional Provisions:

1. Code Change Updates. Updates to billing-related codes (e.g., CPT, HCPCS, ICD-9, DRG, and revenue codes) shall become effective on the date ("Code Change Effective Date") that is the later of: (i) the first day of the month following thirty (30) days after publication by the governmental agency having authority over the applicable product of such governmental agency's acceptance of such code updates; or (ii) the effective date of such code updates, as determined by such governmental agency. Claims processed prior to the Code Change Effective Date shall not be reprocessed to reflect any code updates.

2. Fee Change Updates. Updates to such fee schedule shall become effective on the date ("Fee Change Effective Date") that is the later of: (i) the first day of the month following thirty (30) days after publication by the governmental agency having authority over the applicable product of such governmental agency's acceptance of such fee schedule updates; or (ii) the effective date of such fee schedule updates, as determined by such governmental agency. Claims processed prior to the Fee Change Effective Date shall not be reprocessed to reflect any updates to such fee schedule.

3. Payment under this Exhibit. All payments under this Exhibit are subject to the terms and conditions set forth in the Agreement, the Provider Manual and the Billing Manual.

Definitions:

1. **Allowable Charges** means those Provider billed charges for services that qualify as Covered Services.

Disclosure of Ownership And Control Interest Statement

The federal regulations set forth in 42 CFR 455.104, 455.105 and 455.106 require providers who are entering into or renewing a provider agreement to disclose to the U.S. Department of Health and Human Services, the state Medicaid agency, and to managed care organizations that contract with the state Medicaid agency: 1) the identity of all owners with a control interest of 5% or greater, 2) certain business transactions as described in 42 CFR 455.105 and 3) the identity of any excluded individual or entity with an ownership or control interest in the provider, the provider group, or disclosing entity or who is an agent or managing employee of the provider group or entity. If there are any changes to the information disclosed on this form, an updated form should be completed and submitted to Home State Health Plan. Please attach a separate sheet if necessary to provide complete information.

Practice Information

Check one that most closely describes you: ☐ Individual ☒ Group Practice ☐ Disclosing Entity
Name of Individual, Group Practice, or Disclosing Entity: City of Columbia, Missouri
DBA Name: Columbia/Boone County Public Health and Human Services
Address: 1005 W. Worley St Columbia, MO. 65203
Federal Tax Identification Number: 43-6000810 Provider CAQH #:

Section I

For individuals, list the name, title, address, date of birth (DOB) and Social Security Number (SSN) for each individual having an ownership or control interest in this provider entity of 5% or greater.

For entities, list the name, Tax Identification Number (TIN), business address of each organization, corporation, or entity having an ownership or control interest of 5% or greater. Please attach a separate sheet if necessary.(42 CFR 455.104)

Name of individual or entity	DOB	Address	SSN (if listing an individual) TIN (if listing an entity)

Section II

Are any of the individuals listed above related to each other? ☐ Yes ☐ No

If yes, list the individuals named above who are related to each other (spouse, sibling, parent, child). (42 CFR 455.104)

Names	Type of relation

Section III

Are there any subcontractors that the Disclosing Entity has direct or indirect ownership of 5% or more? ☐ Yes ☒ No

If yes, list the name and address of each person with an ownership or controlling interest in any subcontractor used in which the disclosing entity has direct or indirect ownership of 5% or more. (42 CFR 455.104)

Name of individual or entity	DOB	Address	SSN (if listing an individual) TIN (if listing an entity)

Section IV

Has any person who has an ownership or control interest in the provider, or is an agent or managing employee of the provider ever been convicted of a crime related to that person's involvement in any program under Medicaid, Medicare, or Title XX program? ☐ Yes ☑ No (verify through IUIS-OIG Website)

If yes, please list those persons below. (42 CFR 455.106)

Name/Title	DOB	Address	SSN

Section V

Business Transactions: Has the disclosing entity had any financial transaction with any subcontractors totaling more that $25,000 or any significant business transactions with any subcontractors? ☐ Yes ☑ No

If yes, list the ownership of any subcontractor with whom this provider has had business transactions totaling more than $25,000 during the previous twelve month period; and any significant business transactions between this provider and any wholly owned supplier, or between the provider and any subcontractor, during the past 5-year period. (42 CFR 455.105). Attach a separate sheet if necessary.

Name Supplier/Subcontractor	Address	Transaction Amount

Section VI

Have you identified your status (under Practice Information 1) as a Disclosing Entity? ☐ Yes ☑ No

If yes, for Disclosing Entities, list each member of the Board of Directors or Governing Board, including the name, date of birth (DOB), Address, Social Security Number (SSN), and percent of interest

Name/Title	DOB	Address	SSN	% Interest

I certify that the information provided herein, is true and accurate. Additions or revisions to the information above will be submitted immediately upon revision. Additionally, I understand that misleading, inaccurate, or incomplete data may result in a denial of participation.

Signature _____ **Title (or indicate if authorized Agent)** _____

Name (please print) _____ **Date** _____

Please return the form by fax to [ ] or by mail in the enclosed postage paid envelope to: [ ]

Source: Health

Agenda Item No:

To: City Council

From: City Manager and Staff

Council Meeting Date: Nov 18, 2013

Re: Home State Health Plan
Ancillary Provider Agreement

EXECUTIVE SUMMARY:

A resolution authorizing the City Manager to sign the Ancillary Services Provider Agreement between the City of Columbia and Home State Health Plan.

DISCUSSION:

This contract allows the Department of Public Health and Human Services to bill for approved clinical services provided for Home State Health Plan participants.

FISCAL IMPACT:

This is the first contract for this plan. Revenue will depend on the number of services provided to plan participants. No appropriation is necessary.

VISION IMPACT:
http://www.gocolumbiamo.com/Council/Meetings/visionimpact.php

11.3 Goal: Columbia will be a healthy community. All residents will have timely access to appropriate health care. Effective prevention initiatives will contribute to a healthy community.

SUGGESTED COUNCIL ACTIONS:

Should the Council agree with the staff recommendation, an affirmative vote is in order.

FISCAL and VISION NOTES:					
City Fiscal Impact Enter all that apply		**Program Impact**		**Mandates**	
City's current net FY cost	$0.00	New Program/ Agency?	No	Federal or State mandated?	No
Amount of funds already appropriated	$0.00	Duplicates/Epands an existing program?	No	**Vision Implementation impact**	
Amount of budget amendment needed	$0.00	Fiscal Impact on any local political subdivision?	No	Enter all that apply: Refer to Web site	
Estimated 2 year net costs:		**Resources Required**		Vision Impact?	Yes
One Time	$0.00	Requires add'l FTE Personnel?	No	Primary Vision, Strategy and/or Goal Item #	11.3
Operating/ Ongoing	$0.00	Requires add'l facilities?	No	Secondary Vision, Strategy and/or Goal Item #	
		Requires add'l capital equipment?	No	Fiscal year implementation Task #	