HMC HealthWorks
CONTRACTED PROVIDER AGREEMENT

This **Contracted Provider Agreement** ("**Agreement**"), entered into this ___ day of _____, 2019, is by and between Health Management Concepts, Inc., dba HMC HealthWorks ("**HMC**") and _____ ("**Contracted Provider**").

WHEREAS, HMC has contracted with providers of behavioral health services (which includes mental health and substance abuse inpatient and outpatient services), and other qualified providers of health care services, for the benefit of Members; and

WHEREAS, Contracted Provider is qualified and/or licensed to the extent appropriate and required under state law to provide outpatient/inpatient behavioral health services (which includes mental health and substance abuse inpatient and outpatient services) in the State of _____ and desires to provide services for HMC on an independent contractor basis;

NOW, THEREFORE, the Parties agree as follows:

1 DEFINITIONS

1.1 **"Benefit Contract"** means the written document, which specifies the services and benefits available under a Responsible Payor's health benefits program, as may be amended from time to time.

1.2 **"Benefits" or "Benefit Plans"** means various health care benefit packages offered to Members by HMC or a Responsible Payor.

1.3 **"Clean Claims"** means a request for payment for Covered Services submitted by a Participating Provider which is complete and accurate leaving no issues regarding HMC's or Responsible Payor's responsibility for payment.

1.4 "**Contracted Provider Services**" refers to those outpatient and/or professional health care services, supplies and facilities that Contracted Provider routinely renders to patients, and which Contracted Provider is licensed to provide.

1.5 "**Coordination of Benefits**" means the determination of a Member's benefits when the Member is eligible for benefits under more than one health benefit plan.

1.6 **"Copayment", "Coinsurance" or "Deductible"** means those charges permitted under the Member's Benefit Plan which may be collected directly by Participating Provider as payment for Covered Services.

1.7 "**Covered Services**" means the Medically Necessary health care items and services covered under a Benefit Plan.

1.8 **"Medically Necessary"** or **"Medical Necessity"** are those services provided to identify or treat a Member's mental illness or substance abuse which are determined by HMC or Responsible Payor to be:

a) consistent with the symptoms or diagnosis and treatment of the Member's condition, disease, ailment or injury;

b) consistent with standards of appropriate professional practice;

c) not solely for the convenience of the Member, the Contracted Provider or any other health care provider; and

d) The most appropriate level of service which can be safely provided to the Member.

When specifically applied to a Member receiving inpatient services, "Medically Necessary" or "Medical Necessity" further means that the Member's symptoms or condition requires that the diagnosis or treatment cannot be provided to the Member as an outpatient.

1.9 **"Member"** means a person eligible and entitled to receive benefits under a Benefit Plan.

1.10 **"Non-Contracted Services" means** covered services that are not approved by a Benefit Plan or are provided by an ineligible Person.

1.11 **"Participating Provider"** means a physician, psychiatrist, health professional or any other entity or institutional health care provider under agreement to participate in a provider network administered by HMC.

1.12 "**Procedures**" mean those instructions, rules, and regulations established by HMC or a Responsible Payor, as may be identified in the provider manual and as amended from time to time, which govern the provision of services by Contracted Providers and all other Participating Providers rendering services to Members.

1.13 "**Psychiatric Emergency Admission**" or "**Psychiatric Emergency**" means an immediate and unscheduled admission or treatment of a Member evidencing a diagnosis from the most recently published edition of *The Diagnostic and Statistical Manual of Mental Disorders*, with symptoms of such severity that the impairment of functioning presents an immediate danger to self or others. The determination of whether a particular set of facts constitutes a Psychiatric Emergency shall be made by HMC or Responsible Payor in conformity with applicable Psychiatric Emergency criteria.

1.14 **"Responsible Payor"** means an entity liable for making benefit payments under a Benefit Contract, or an entity with a fully or partially self-funded Benefit Plan administered by HMC, which entity is financially responsible for paying Benefits for Covered Services rendered to Members. Responsible Payors may be health maintenance organizations (HMOs), Preferred Provider Organizations (PPOs), insurers, employers, self-funded employers, self-funded trust funds or other entities.

1.15 **"Utilization Review"** means a function performed by HMC or Responsible Payor, or by an organization or entity selected by HMC or Responsible Payor, to review and determine whether Contracted Provider Services and hospital services provided or to be provided are Medically Necessary, including but not limited to whether acute care hospitalization, length-of-stay, outpatient care, or diagnostic ancillary services are necessary and appropriate for a Member's medical condition.

II. CONTRACTED PROVIDER'S MATTERS

2.1 **Authorization to Enter into Contracts with Responsible Payors.**
Contracted Provider hereby authorizes HMC, on Contracted Provider's behalf, to enter into contracts with Responsible Payors who provide Benefit Plans or administer employers' self-funded Benefit Plans. For each Benefit Plan, Contracted Provider shall render Covered Services to Members subject to the applicable terms and provisions of this Agreement and the applicable Benefit Contract.

2.2 **Provision of Services**

2.2.1 Contracted Provider agrees to provide all Covered Services required by any Member as identified by HMC at the time of a referral.

2.2.2 In the event a Member requires any behavioral health services (which includes mental health and substance abuse inpatient and outpatient services) or other medical services which are beyond the scope of Contracted Provider Services, Contracted Provider agrees to refer the Member to another Participating Provider consistent with the Procedures established by HMC and/or Responsible Payor.

2.2.3 Contracted Provider agrees that all Covered Services shall be provided at locations mutually agreed upon by the Parties; provided that such locations shall be adequate to ensure the delivery of Covered Services to Members.

2.2.4 Following each occasion on which Covered Services are rendered to a Member, including Psychiatric Emergency services, Contracted Provider agrees to send a report of the services rendered to such Member to HMC or Responsible Payor, in accordance with applicable Procedures.

2.2.5 Contracted Provider will provide Covered Services promptly and in a manner that assures continuity of care, including reasonable hours of operation and provision for after-hours services. Contracted Provider will provide or arrange on-call coverage with another Participating Provider for emergency care services to Members twenty-four (24) hours a day, seven (7) days a week.

2.2.6 Contracted Provider agrees not to discriminate or differentiate in the treatment of any Member based on sex, marital status, sexual orientation, age, race, color, disability, religion, or otherwise, including by reason of the fact that the individual is a Member under a Benefit Contract. Contracted Provider agrees to ensure that Covered Services are provided to Members in the same manner, and in accordance with the same standards and with the same availability as offered to any other individual customarily receiving services from Contracted Provider, which shall be in accordance with accepted standards of competence and ethics.

2.3 **Authorizations for Covered Services**

2.3.1 Contracted Provider agrees that to the extent provided in the Benefit Contract, authorizations for Covered Services shall be as designated by HMC, Responsible Payor or the selected Utilization Review entity. Visits beyond the specified time period authorized shall require additional authorization from HMC, Responsible Payor, or the selected Utilization Review entity.

2.3.2 In the case of Psychiatric Emergencies, Contracted Provider agrees to obtain, where feasible and consistent with the appropriate standard of care, from a twenty-four hour on-call service provided by HMC or other mechanism used by Responsible Payor or their designee, prior approval for any services not pre-authorized in accordance with Section 2.3.1 of this Agreement.

2.4 **Licenses**

2.4.1 Contracted Provider possesses all required State and Federal licenses relating to the provision of services to Members in the State where such services are to be rendered and meets all requirements of Federal and State statutes and regulations that apply to provision of such services. Contracted Provider agrees to comply with all licensing requirements applicable to its director and all employees, agents, and contractors providing services to Members. In the case of a license suspension, revocation, or loss, Contacted Provider must immediately notify HMC.

2.4.2 Contracted Provider shall provide HMC or its designee all information required under HMC's credentialing program. Contracted Provider acknowledges that his/her

participation pursuant to this Agreement may be rejected, terminated, or suspended pursuant to the credentialing program.

2.5 **Hospital Affiliation.** If Contracted Provider routinely admits Members for inpatient hospitalization, Contracted Provider shall maintain membership on the staff of at least one of the hospitals holding a current agreement with HMC, and shall have appropriate privileges within his/her specialty area of practice. Contracted Provider shall immediately notify HMC in the event such membership and/or clinical privileges are modified, suspended, or revoked.

2.6 **Delegation/Subcontracting.** Contracted Provider agrees not to delegate or subcontract any professional duties to any other provider or clinician without the approval of HMC. Contracted Provider shall submit to HMC, for HMC's approval in its sole discretion, credentials for clinicians to whom professional duties may be delegated or subcontracted, in accordance with HMC's standard Procedures. Contracted Provider shall clinically supervise and review all Covered Services rendered to Members to ensure compliance with the terms of this Agreement.

2.7 **Insurance.** Contracted Provider agrees to procure and maintain at its own expense throughout the duration of this Agreement such policies of general, professional liability and other insurance as shall be necessary to ensure Contracted Provider against any claim or claims for damages arising by reason of personal injuries or death occasioned directly or indirectly in connection with the performance of any service by Contracted Provider or any of its employees or independent contractors. At a minimum, Contracted Provider agrees that any such professional liability insurance policy shall be maintained for physicians with limits of at least $1,000,000 per occurrence, $3,000,000 in the aggregate, on an occurrence basis or on a claims-made basis with an equivalent amount of tail coverage. Upon request, certificates of insurance and memorandum copies of such insurance policies shall be delivered to HMC. Contracted Provider agrees to notify HMC immediately with respect to any changes in the amount or status of any such insurance coverage.

2.8 **Member Complaints.** If any complaints are received from Members by Contracted Provider regarding Contracted Provider, Participating Providers, or HMC, Contracted Provider agrees to promptly notify HMC concerning all details of such complaint. If such complaints regarding Contracted Provider are received directly by HMC, HMC will promptly notify Contracted Provider. Contracted Provider and HMC agree to cooperate fully towards the investigation and resolution of any such complaint by a Member.

2.9 **Records**

2.9.1 Contracted Provider agrees to maintain such records relating to its obligations under this Agreement, including medical records describing services rendered and related financial records and such information as may be necessary for compliance with the provisions of any applicable law and regulations. These records shall be retained for seven (7) years form the date of performance of the last Covered Services, be in writing, and comply with legal standards, generally accepted business and professional standards and this Agreement. Contracted Provider further agrees that this provision shall survive any termination of this Agreement.

2.9.2 HMC shall have the right to inspect in person at all reasonable times and with reasonable notice any medical and other records maintained by Contracted Provider pertaining to the treatment of Members; provided that HMC may, upon request, require Contracted Provider to make such records available to, the applicable Responsible Payor or any government agency. Contracted Provider agrees to allow duplication of any and all data, billings, and other records maintained on Members. Duplication shall occur upon reasonable notice during regular working hours, and without charge to HMC or Responsible Payor.

2.9.3 All medical records of any Member shall be treated as confidential, so as to comply with all federal and state laws and regulations.

2.9.4 Contracted Provider agrees to cooperate with HMC in any system which will facilitate, to the extent feasible, the maximum sharing of records between Contracted Providers and Participating Providers to whom duties are delegated as permitted by this Agreement. This shall include sending a copy of a Member's treatment record to such Participating Providers, without charge.

2.10 **Professional Responsibility.** Nothing in this Agreement shall be deemed to change or alter any relationship, which exists or may come to exist between Contracted Provider and any Member. Contracted Provider shall have and be subject to the same duties, liabilities and responsibilities toward Member as exists generally between patients and health care providers. Further, the Utilization Review and quality assurance Procedures of HMC or Responsible Payor shall not diminish Contracted Provider's obligation to render Covered Services consistent with the applicable standard of care.

2.11 **Roster.** Contracted Provider agrees that HMC or Responsible Payors may use Contracted Provider's name, address, telephone number, and description of specialty area and services in promotional materials and listings of Participating Providers developed by HMC or Responsible Payors.

2.12 **Notice of Certain Matters.** Contracted Provider agrees to notify HMC immediately upon the occurrence of any of the events or actions set forth in Section 6.4 or the issuance of any notice, charges or similar documents alleging the occurrence or any such event or action.

III. PAYMENT FOR CONTRACTED PROVIDER SERVICES

3.1 **Full Payment.** Contracted Provider shall seek payment from HMC or Responsible Payor, as appropriate, only for the provision of Covered Services. Contracted Provider agrees to accept the reimbursement set forth in Exhibit 1 (Schedule of Payments) as payment in full for Covered Services rendered to Members. Further, Contracted Provider shall look solely to HMC or Responsible Payor, as appropriate, for such reimbursement and shall not seek compensation from Members, except as set forth in Section 3.4 of this Agreement.

3.2 **Billing**

3.2.1 Contracted Provider shall submit bills for Covered Services rendered to Members in accordance with the applicable procedures developed for each Responsible Payor. Billings shall include detailed and descriptive medical and patient data and identifying information on a CMS 1500 or other approved industry standard format form. Statements submitted by Contracted Provider must specify the duration and type of services rendered and the current edition CPT-IV procedure code.

3.2.2 Contracted Provider will submit claims for Covered Services within thirty (30) days of the date of service. Claims submitted more than ninety (90) days following the date of service may be denied. Contracted Provider agrees to only seek payments for services rendered in accordance with the Utilization Review and quality assessment program outlined in Article V of this Agreement.

3.3 **Member Hold Harmless**

3.3.1 Contracted Provider or its assignee or subcontractor, hereby agrees that in no event, including, but not limited to non-payment by HMC or Responsible Payor, HMC or Responsible Payor insolvency or breach of this Agreement, shall Contracted Provider, its assignee or subcontractor, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Members or persons, other than HMC or Responsible Payor, acting on their behalf for services provided pursuant to this Agreement. This provision shall not prohibit collection of supplemental charges or co-payments on HMC's or Responsible Payor's behalf made in accordance with terms of the Benefit Contract.

3.3.2 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 Member and that (2) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Contracted Provider and subscriber/enrollee or persons acting on their behalf.

3.4 **Member Payments**

3.4.1 Contracted Provider agrees that the only charges for which a Member may be liable and be billed by Contracted Provider shall be for Non-Covered Services, Copayments, Deductibles, and/or Coinsurance. Further, Contracted Provider agrees not to implement any policy that would circumvent the obligation of the Member to pay any Non-Covered Service, Copayment, Deductible, and/or Coinsurance amounts as provided in the applicable Benefit Contract.

3.4.2 Neither HMC nor Responsible Payor shall be liable for Non-Covered Services, Copayments, Deductibles, and/or Coinsurance. HMC or Responsible Payor shall deduct any Non-Covered Service, Copayments, Deductibles, and/or Coinsurance required by the applicable Benefit Contract from payments due Contracted Provider from HMC or Responsible Payor.

3.4.3 Notwithstanding anything to the contrary in this Agreement, neither Member, HMC or Responsible Payor shall be liable for payment for any Contracted Provider Services which are determined not to be Medically Necessary; provided however, if a Member assumes financial responsibility in writing and requests Contracted Provider Services after being informed by Contracted Provider prior to the rendition of such Contracted Provider Services that the Contracted Provider Services have been determined to be not Medically Necessary, Member shall be solely liable for payment.

3.5 **Coordination of Benefits**

3.5.1 Contracted Provider agrees to assist HMC or Responsible Payor in the Coordination of Benefits provided to Members and Member information, including with respect to third-party claims.

3.5.2 In a case in which HMC or Responsible Payor, under the applicable Benefit Contract, is primary under applicable Coordination of Benefit rules, Exhibit 1 (Schedule of Payments) shall apply.

3.5.3 In a case in which HMC or Responsible Payor, under the applicable Benefit Contract, is other than primary under the Coordination of Benefit rules, only those amounts shall be paid which, when added to the amounts received by Contracted Provider from other sources, pursuant to the applicable Coordination of Benefit rules, equal one hundred percent (100%) of the reimbursement amount specified in HMC's rate schedule.

3.5.4 Contracted Provider also may seek payment for the provision of Contracted Provider Services from other sources as available pursuant to the Coordination of Benefit provisions of the applicable Benefit Contract. In such cases, Contracted Provider may seek payment on a basis other than the rate referred to in HMC's rate schedule.

IV. HMC MATTERS

4.1 **Schedule of Payments.** HMC or Responsible Payor shall pay Contracted Provider compensation pursuant to the provisions set forth in Exhibit 1, Schedule of Payments.

4.2 **Identification Cards.** HMC or Responsible Payor shall provide appropriate identification cards for Members.

4.3 **Clean Claims.** HMC shall process in the normal course and pay Clean Claims within thirty (30) days of receipt. HMC may deny payment for any claims that fail to meet HMC's submission requirements for such claims or which are received after the time limit, under this Agreement, for submitting Clean Claims.

4.4 **Non-Interference with Treatment.** HMC acknowledges that Contracted Provider shall have sole responsibility for all professional decisions and determinations of the manner and means by which the treatment needs of Members shall be met.

V. UTILIZATION REVIEW AND QUALITY ASSURANCE PROGRAM

5.1 **Establishment of UR/QA Program.** HMC or Responsible Payor shall establish a Utilization Review and quality assurance program, which shall seek to avoid unnecessary or unduly costly behavioral health services while ensuring the delivery of quality health care services, which are considered Medically Necessary for Members, including quality assurance, medical and case management, credentialing, peer review and grievance programs and procedures. Contracted Provider agrees to cooperate with such programs and procedures.

5.2 **Peer Review and Grievance Mechanisms.** Contracted Provider agrees to comply with and be bound by all final determinations rendered by HMC's or the applicable Responsible Payor's peer review process or grievance mechanism, as it relates to any Member receiving Covered Services from Contracted Provider under this Agreement.

5.3 **Right of Appeal.** In the event Contracted Provider does not agree with a denial of payment determination made by HMC or a Responsible Payor, an appeal may be filed with HMC or the Responsible Payor, as appropriate. HMC or Responsible Payor, as appropriate, shall review such appeal in accordance with the applicable appeal procedures of the program.

VI. TERM AND TERMINATION

6.1 **Term.** The initial term of this Agreement shall commence on the date first above written and shall continue in effect for one year. Thereafter, this Agreement will automatically renew for successive one year periods, unless otherwise terminated in accordance with the terms of this Agreement.

6.2 **Termination Without Cause.** Either party may terminate this Agreement without cause, during its initial or any subsequent term, by providing the other party written notice at least ninety (90) days in advance of such termination.

6.3 **Termination for Material Breach.** Either party may terminate this Agreement by providing the other party with a minimum of thirty (30) days prior written notice in the event the other party commits a material breach of any provision of this Agreement. Said notice must specify the nature of said material breach. The breaching party shall have twenty (20) days from the date of the breaching party's receipt of the foregoing notice to cure said material breach to the reasonable satisfaction of the non-breaching party. In the event the breaching party fails to cure the material breach within said twenty (20) day period, this Agreement shall automatically terminate upon expiration of the thirty (30) day notice period.

6.4 **Criteria for Immediate Termination**

HMC reserves the right to terminate this Agreement immediately by written notice to Contracted Provider upon the occurrence of:

a) The termination of HMC's obligation to provide behavioral health services (including mental health and substance abuse inpatient and outpatient services) to any Responsible Payor;

b) The imposition of any sanction, including but not limited to civil monetary fines or penalties, by any state or federal agency against Contracted Provider or against Contracted Provider's license or eligibility to receive reimbursement from the Medicare or Medicaid Programs; or against the license or eligibility for Medicare or Medicaid reimbursement of any providers or clinicians rendering Covered Services under a contract with Contracted Provider;

c) Contracted Provider's violation of any of the provisions of the applicable Utilization Review program as described under Article V of this Agreement;

d) Contracted Provider's failure to maintain the insurance policies specified under Article VII of this Agreement;

e) Contracted Provider's non-acceptance of any proposed amendment designated as a material amendment in the notice thereof pursuant to section 7.7 of this Agreement; or

f) Contracted Provider's conviction, guilty plea or plea of nolo contendere to any felony or crime involving moral turpitude.

6.5 **Obligations Following Termination**

Contracted Provider shall continue to provide Covered Services in accordance with the terms of this Agreement to Members who are receiving active treatment on the date of termination until those services are completed, or until medically appropriate arrangements have been made to transfer the responsibility for care of the Member to another Participating Provider, or until such patient is no longer a Member. The termination of this Agreement shall not affect any rights to compensation for Covered Services rendered prior to termination.

VII. MISCELLANEOUS

7.1 **Dispute Resolution.** HMC and Contracted Provider agree to meet and confer in good faith to resolve any problems or disputes that may arise under this Agreement. In the event that any problem or dispute other than a grievance decision provided for in Section 5.2 is not satisfactorily resolved, HMC and Contracted Provider agree to arbitrate such problem or dispute. Such arbitration shall be initiated by either party making a written demand for arbitration on the other party pursuant to JAMS rules before a single arbitrator. The arbitrator shall hold a hearing and decide the matter within thirty (30) days thereafter. HMC and Contracted Provider agree that the arbitration results shall be binding on both parties in any subsequent litigation or other dispute. The fees and expenses of the arbitrators shall be borne equally by the parties. Each party shall pay its own fees and costs relating to any arbitration proceedings, including attorney's fees.

7.2 **Headings.** The headings of paragraphs contained in this Agreement are for reference purposes only and shall not affect in any way the meaning or interpretation of this Agreement.

7.3 **Waiver of Breach.** The waiver of either party of a breach or violation of any provision of this Agreement shall not operate as or be construed to be a waiver of any subsequent breach thereof.

7.4 **Successors and Assigns.** This Agreement, being intended to secure the services of professional practice, shall not be assigned, sublet, delegated or transferred without the prior written consent of

HMC. HMC may assign its rights and responsibilities under this Agreement to an affiliate or successor. This Agreement shall be binding upon the parties, their successors and assigns.

9.5 **Relationship of the Parties.** None of the provisions of this Agreement is intended to create nor shall be deemed or construed to create any relationship between the parties hereto other than that of independent entities contracting with each hereunder solely for the purpose of effecting the provisions of this Agreement. Neither the parties hereto, nor any of their respective employees, shall be construed to be the agent, employer or representative of the other. Except as specifically provided herein, this Agreement shall not create or be construed to create in any manner whatsoever any rights in any individual as a third-party beneficiary of this Agreement or otherwise.

9.6 **Severability.** In the event of any law, or applicable administrative rule or regulation, shall render the performance of any obligation under this Agreement impossible or in violation of any such law, rule or regulation, the parties agree to the extent possible and consistent with the intent of this Agreement, that the parties shall remain obligated hereunder in accordance with such law, rule or regulation.

9.7 **Amendments.** Except as otherwise set forth in this Agreement, any amendments to this Agreement shall be in writing and signed by both parties. However, HMC may amend this Agreement unilaterally upon 30 days' prior notice to Contracted Provider, and if Contracted Provider objects to the amendment, Contracted Provider shall notify HMC of the objection within the thirty (30) day notice period, and HMC may terminate this Agreement for convenience in accordance with this Agreement.

9.8 **Notices.** Any notice which by the terms of this Agreement may be given to either party shall be in writing and shall be sent to the following addresses:

For Contracted Provider:

_____

_____

_____

For HMC:

Health Management Concepts, Inc.
Attention: Provider Relations Department
5840 Banneker Rd, Suite 270
Columbia, MD 21044

A party's address may be changed at any time by written notice mailed to the other party at the address listed above.

Notices of termination or non-renewal of this Agreement shall be sent by facsimile, courier, or certified mail. All other notices may be sent by regular U.S. mail.

9.9 **Governing Law.** This Agreement shall be governed in all respects by applicable federal laws and the laws of the State of Florida.

9.10 **Entire Agreement.** This Agreement constitutes the complete understanding of the parties with respect to the subject matter, and supersedes any prior agreements, promises, negotiations or

representations, whether written or oral, related to the subject matter of the Agreement that are not expressly set forth in this Agreement.

IN WITNESS WHEREOF, the undersigned have executed this Agreement as of the date and year first above written.

FOR HMC:	**FOR Contracted Provider:**
Signature	Signature
Print Name	Print Name
Title	Title
Date	Date
	Federal Tax ID

Exhibit 1
Schedule of Payments