

# NEW DIRECTIONS BEHAVIORAL HEALTH, LLC FLORIDA PROVIDER AGREEMENT

This Florida Provider Agreement (Agreement) is made and entered into by and between New Directions Behavioral Health, LLC, on behalf of itself and its Affiliates (New Directions), and \_\_\_\_\_ (Provider), as of \_\_\_\_\_ (Effective Date).

**WHEREAS**, New Directions has contracts with Plans and employers to provide or arrange for mental health, substance abuse, and wellness benefits to Members;

**WHEREAS**, New Directions contracts with health care providers to render services to Members;

**WHEREAS**, Provider is a health care provider and wishes to contract with New Directions to provide services to Members on the following terms and conditions;

**NOW, THEREFORE**, in consideration of the foregoing and of the mutual covenants, promises, and undertakings herein and intended to be legally bound hereby, the Parties agree as follows:

## 1. **DEFINITIONS**

When used in this Agreement, all capitalized terms shall have the following meanings unless otherwise defined by applicable law or Plan:

- 1.1 **Affiliate**. Affiliate shall mean any corporation, limited liability company, partnership, or other legal entity directly or indirectly owned or controlled by, or which owns or controls, or which is under common ownership with, New Directions, or any entity designated by Payor.
- 1.2 **Business Day**. Business Day means in the calculation of a period, Saturdays, Sundays, and Federal holidays will be excluded.
- 1.3 **Clean Claim**. Clean Claim means a claim that has no defect or impropriety, including any lack of required substantiating documentation, or particular circumstances requiring special treatment that prevents timely payment from being made on the claim, which has been submitted on the appropriate form within the timeframe as set forth by the applicable Plan.
- 1.4 **Coinsurance, Copayment, Deductible**. Coinsurance, Copayment, and Deductible mean a fixed dollar amount or percentage portion of the cost of Covered Services which is to be paid by Members.
- 1.5 **Covered Services**. Covered Services means those Medically Necessary services and supplies which are within Provider's professional license or certification and scope of practice and competency and which a Member is entitled to receive payment for under the terms and conditions of the Member's Plan.

- 1.6 Emergency Medical Condition. Emergency Medical Condition means the sudden and, at the time, unexpected onset of a health condition that manifests itself by acute symptoms of sufficient severity, including severe pain, psychiatric disturbances, and symptoms of substance abuse, that would lead a prudent lay person, possessing an average knowledge of health and medicine, to believe immediate medical care is required, which may include, but shall not be limited to: (a) placing the health of the Member, or with respect to a pregnant Member, the health of the pregnant Member or her unborn child, in serious jeopardy; (b) serious impairment to a bodily function; (c) serious dysfunction of any bodily organ or part; (d) inadequately controlled pain; or (e) with respect to a pregnant Member having contractions that (i) there is inadequate time to effect a safe transfer to another hospital before delivery, or (ii) a transfer may pose a threat to the health or safety of the pregnant Member or her unborn child.
- 1.7 Emergency Services. Emergency Services shall mean health care items and services furnished or required to screen and stabilize an Emergency Medical Condition which may include, but shall not be limited to, health care services that are provided in a licensed hospital's emergency facility by an appropriate health care provider.
- 1.8 Medically Necessary or Medical Necessity. Medically Necessary or Medical Necessity means services and supplies based upon generally accepted medical practices in light of the condition at the time of treatment which are: (i) appropriate and consistent with the diagnosis and the omission of which could adversely affect or fail to improve the Member's condition; (ii) provided in a safe and appropriate setting given the nature of the diagnosis and the severity of the symptoms; and (iii) not provided solely for the convenience of the Member or Provider.
- 1.9 Member. Member means any person covered under a Plan.
- 1.10 New Directions Website. The Website for New Directions is [www.ndbh.com](http://www.ndbh.com).
- 1.11 Network Facility. Network Facility means a facility that has been credentialed by New Directions and has entered into an agreement with New Directions or with another entity that has an agreement with New Directions, to provide Covered Services to Members.
- 1.12 Network Provider. Network Provider means an individual health care provider who has been credentialed by New Directions and has entered into an agreement with New Directions or with another entity that has an agreement with New Directions, to provide Covered Services to Members.
- 1.13 Payment Rate. Payment Rate means the amount paid to a Provider under the terms of this Agreement and which amount Provider agrees to accept as

full and final payment for Covered Services provided to Members, in conjunction with Copayments, Coinsurance, and Deductibles and/or amounts due for non-Covered Services. Payment Rates may be adjusted from time to time as set forth in this Agreement.

- 1.14 Payor. Payor means New Directions, employers, insurers, third party administrators, or other entities which have agreed to be responsible for funding benefit payments for Covered Services provided to Members under the terms of a Plan.
- 1.15 Plan. Plan means any health benefit product or plan issued, administered, or serviced by New Directions or one of its Affiliates.
- 1.16 Provider Network. Provider Network is those providers who have been credentialed by New Directions to provide Covered Services to Members in designated Plans.

## 2. **PROVISION OF SERVICES**

- 2.1 Identification and Eligibility Verification. New Directions shall through its Website make available to Provider eligibility information regarding all Members. Members shall be provided with a card indentifying the Member, the Plan, and how Provider can seek authorization for payment of services (Identification Card). Provider shall use all reasonable efforts to verify the eligibility and identity of Members including checking Identification Cards, Member listings, or contacting New Directions.
- 2.2 Plan Terms. New Directions shall make available to Provider Plan terms through its Website and in the current edition of the New Directions Provider and Facility Manual. Provider shall be responsible for consulting the applicable Plan terms for Members to determine what are Covered Services and other requirements that must be met for those Plan Members, including when preauthorization or prenotification is required.
- 2.3 Authorization. Except in the case of an Emergency Medical Condition, prior to providing services to a Member, Provider will comply with any preauthorization or prenotification procedures of the Plan or New Directions to verify that such person is a Member, that the services to be provided constitute Covered Services, and that payment for the Covered Services is authorized. Members shall be held harmless if Provider fails to obtain required authorizations.
- 2.4 Emergency Services. In the case of an Emergency Medical Condition of a Member, Provider shall provide Emergency Services in accordance with applicable law, and shall notify Payor within 24 hours after the provision of Emergency Services or as required by the applicable law or Plan.

- 2.5 Provision of Covered Services. Provider shall furnish to Member those Covered Services set forth in the applicable Plan. Provider is designated as a “Network Provider” in all of the products managed by New Directions unless notified otherwise. It is understood and agreed that Payor shall have the final authority to determine whether any services provided by Provider were Covered Services and to adjust or deny payment for services rendered by Provider to Members in accordance with the results of such determinations.
- 2.6 Nondiscrimination. Provider agrees to accept Members from any Plan who need Covered Services. Covered Services shall be delivered in a prompt manner, consistent with medical and ethical standards. Provider shall not differentiate or discriminate in the treatment of Members or in the quantity or quality of Covered Services provided to Members on the basis of age, sex, race, color, religion, national origin, ancestry, disability, Vietnam-era veteran’s status, that the Member is a Medicare Member or Medicaid Member, or on the basis of any other applicable State or Federal law. Provider agrees to provide understandable and respectful care that is culturally sensitive to the Member.
- 2.7 Treatment. Provider understands that the ultimate responsibility for the rendering of Covered Services to Members is that of Provider. Nothing contained in this Agreement shall impinge upon the independent clinical judgment of Provider.
- 2.8 Advising or Advocating for Members. Nothing in this Agreement is intended to prohibit or restrict Provider from advising or advocating for a Member in any respect, including, but not limited to:
- (a) For the Member’s health status, medical care, or treatment options, including any alternative treatment that may be self-administered;
  - (b) For any information the Member needs to decide among all relevant treatment options;
  - (c) For the risks, benefits, and consequences of treatment or non-treatment; and
  - (d) For the Member’s right to participate in personal health care decisions, including the right to refuse treatment and to express preferences about future treatment decisions.
- 2.9 Determining Medical Necessity. In the event New Directions determines that a service is not Medically Necessary, Provider may appeal the determination in accordance with New Directions’ grievance policy and applicable law.

3. **REPRESENTATIONS**

- 3.1 **Qualifications.** Provider shall maintain throughout the term of this Agreement all appropriate licenses and/or certifications mandated by governmental regulatory agencies required for Provider to provide Covered Services to Members.
- 3.2 **Accessibility.** Provider agrees to provide Covered Services to Members during Provider's normal business hours, and to provide or arrange for the provision of emergency, evening, weekend, holiday, and vacation coverage through other Providers such that there is coverage 24 hours a day, 7 days per week, 365 days per year. Provider agrees to schedule appointments for Members as required by New Directions or the applicable Plan terms.
- 3.3 **Credentialing.** Provider agrees to cooperate with a periodic re-evaluation of credentials conducted by New Directions with the understanding that approval of reappointment to a Provider Network is necessary for this Agreement to be effective.

4. **PAYOR AND PROVIDER OBLIGATIONS**

- 4.1 **Explanation of Benefits.** New Direction shall have available on its Website and in the New Directions Provider and Facility Manual an explanation of benefits for each Plan, utilization standards, administrative requirements, and other related information.
- 4.2 **Collection of Coinsurance, Copayments, and Deductibles.** Provider shall be responsible for collecting from Members all applicable Coinsurance, Copayments, and Deductibles, and may collect such sums from Members at the time of service. Provider shall not waive any Coinsurance, Copayment, or Deductible, or any payment due to Provider which is a Member's responsibility without prior written approval of New Directions. Provider shall refund to the Member any funds overpaid or paid in error within 30 calendar days or as required by applicable law or Plan terms.
- 4.3 **Billing of Members.** Provider agrees that in no event, including, but not limited to, nonpayment by Payor, insolvency of Payor, or breach of this Agreement by New Directions, shall Provider bill, charge, collect, seek compensation or reimbursement from, or have any recourse against a Member for Covered Services rendered under this Agreement. Provider is not prohibited from collecting fees for non-Covered Services delivered on a fee-for-service basis to Members. This Agreement shall not prohibit a Provider and Member from agreeing to continue services solely at the Member's expense provided the Provider has clearly informed the Member that Payor will not cover such services. Except as provided herein, this

Agreement doesn't prohibit Provider from pursuing any legal remedy including, but not limited to, collecting from any Payor providing coverage to a Member.

Provider further agrees that this Section 4.3: (a) shall survive termination of this Agreement; (b) shall be construed to be for the benefit of the Member; and (c) supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and a Member or person acting on Member's behalf.

- 4.4 Coordination of Benefits. Payor and Provider shall cooperate and exchange information regarding alternative health coverage of Members and other information relative to coordination of benefits. Provider shall promptly notify Payor of any known potential or actual duplicate coverage circumstances.
- 4.5 Claims Submission. Provider shall submit claims to the applicable Payor for Covered Services provided to Members. Claims shall be submitted within the time frame designated by the applicable Plan and to the address for the applicable Payor as set forth on the New Directions Website and in the New Directions Provider and Facility Manual. Claims shall be submitted on the forms required by Payor with Provider's tax identification number, NPI, the assigned Plan number (if applicable), and all other required information by means of the electronic data interchange (EDI) or as otherwise acceptable to Payor. Payor may reduce or deny payment of claims which are not submitted in accordance with the applicable Plan and Payor requirements, or which are not billed or coded in accordance with generally accepted industry standards for billing and coding practices.
- 4.6 Request for Information. Payor shall advise Provider of all objections to or deficiencies in any submitted claim within 30 calendar days, or within a shorter time frame if required by applicable law, after Payor's receipt of such claim.
- 4.7 Payment. Provider shall be paid by Payor for Covered Services that are Medically Necessary and correctly submitted as Clean Claims, as set forth in Section 4.5, in accordance with the Payment Rates set forth in Exhibit 1, attached hereto and incorporated herein by reference, or Provider's billed charges, whichever is lower, and Provider agrees to accept such compensation as payment in full. Payor shall make payments to Provider within 30 days of Payor's receipt of a Clean Claim, or within such shorter period as may be required by applicable law. Except for applicable Copayments, Coinsurance, and Deductibles, Provider shall look only to Payor for compensation for Covered Services provided to Members.

- 4.8 Late Payment Interest. If Payor fails to make payment on a Clean Claim that has been correctly submitted within the time period specified in Section 4.7, or as otherwise required by applicable law, Payor shall be obligated to pay interest as required by applicable law.
- 4.9 Overpayments and Underpayments. Overpayments and underpayments shall be processed in accordance with laws, as applicable, and in accordance with New Directions' and Payor's policies and procedures.

5. **COMPLIANCE WITH LAWS, POLICIES AND PROVIDER AND FACILITY MANUAL**

- 5.1 Agreement to Comply. Provider agrees to abide by and comply with all applicable State and Federal laws, New Directions' policies, and with the procedures as set forth in the New Directions Provider and Facility Manual; however, if any policy or any procedure is inconsistent with any provision in this Agreement, the applicable provision in this Agreement shall prevail. New Directions represents and warrants that the New Directions Provider and Facility Manual will be timely updated with any changes. New Directions will make available to Provider through its Website policies it deems pertinent to Provider or hard copies upon Provider's request.
- 5.2 Quality Improvement Program and Utilization Management Program. Provider agrees to participate as requested and comply with the New Directions Quality Improvement Program (QIP) and Utilization Management Program (UMP) to promote quality of care and appropriate and efficient use of resources.
- 5.3 Notices and Reporting. Provider agrees to notify New Directions within 72 hours in writing of any of the following:
- (a) Change in business address, phone number, fax number, or email address;
  - (b) Change in professional licensure or registration status, Drug Enforcement Administration registration, State drug registration, or professional liability insurance;
  - (c) Conviction or a plea of guilty or nolo contendere of a felony or any offense reasonably related to the qualifications, functions, or duties of Provider; or any offense an essential element of which is fraud, dishonestly, or an act of violence;
  - (d) Change in privileges or membership of any health care organization;
  - (e) Impairment or illness that affects Provider's ability to effectively and appropriately practice Provider's profession;
  - (f) Sanctions related to Medicare or Medicaid provider agreements;

- (g) Adverse determination by a professional review body or third-party payor reimbursement program concerning quality of care;
- (h) Commencement of a formal investigation or the filing of charges by a State Attorney General, Department of Health and Human Services, or Department of Justice, or any felony or misdemeanor charge filed by a health regulatory agency;
- (i) Extended leave of absence from Provider's practice; or
- (j) Any other changes in practice, credentials, or circumstances that may affect care of Members by Provider.

5.4 Confidential and Proprietary Information. New Directions and Provider each acknowledge that during the performance of this Agreement each may obtain or become aware of confidential and proprietary information of the other Party including, but not limited to: mailing lists; patient/Member lists; employer lists; product-related information and structure; utilization review procedures; quality improvement processes; documents concerning a Party's systems and operations; clinical practice guidelines; report formats; customer databases; and other information not in the public domain (Proprietary Information). Proprietary Information shall not include information which is required by law or a government agency to be disclosed.

Both Parties agree to maintain the confidentiality of the other Party's Proprietary Information, and further agree that such Proprietary Information will not be disclosed to any direct competitor of the other Party, or to any other third party, other than to fulfill the terms of this Agreement, without the written consent of the other Party, except as may be required by law. Each Party agrees that upon termination of this Agreement, it will return to the other Party all of such other Party's Proprietary Information, or upon such other's request will destroy Proprietary Information and provide to that Party satisfactory proof of destruction.

Each Party agrees that, immediately upon its receipt of any subpoena or court order for production or disclosure of the other Party's Proprietary Information, it shall notify the other Party and reasonably cooperate in obtaining any protective order or other appropriate remedy sought by the other Party.

## 6. INSURANCE AND INDEMNIFICATION

6.1 Provider's Insurance. During the entire term and any renewal term of this Agreement, Provider shall maintain professional liability insurance at least at

minimum levels required from time to time by New Directions. In the event that coverage is of a claims-made variety, Provider shall continue to maintain policies of insurance in effect for a period of 3 years beyond the term or any renewal term of this Agreement to cover claims that occur during the effectiveness of this Agreement.

- 6.2 Defense Cooperation. Each Party may from time to time be faced with certain legal issues, actions, or claims arising from or related to its services under this Agreement. Each Party recognizes the value in cooperating with the other in good faith when such issues, actions, or claims arise, to the extent such cooperation doesn't violate any applicable laws, result in a breach of any insurance policy, or result in a breach of any confidentiality or privilege. Each Party agrees to notify the other Party within 20 calendar days of receipt of any lawsuits, claims, regulatory actions, or notices of intent to file a lawsuit based on the services provided under this Agreement. Each Party shall cooperate in good faith, using their best efforts, to address issues in a manner that encourages full cooperation between the Parties.

## 7. INSPECTION OF RECORDS AND DATA ACCESS

- 7.1 Access to Information. Provider shall grant to New Directions, on behalf of New Directions and its Affiliates, access to all data and information obtained, created, or collected by Provider related to Members including, but not limited to, records, books, and papers relating to professional and ancillary care provided to Members and financial, accounting, and administrative records, books and papers (Information), to the extent permitted by and otherwise consistent with applicable laws. New Directions shall have reasonable unlimited free access to Information in electronic or other form, and shall not be required to pay any access, transaction, or other fees to obtain such Information for claims adjudication, quality improvement activities, utilization management, professional review activities, and other similar healthcare operations of New Directions.
- 7.2 Audits, Evaluations, and Inspections. Provider shall cooperate and comply with any audits, evaluations, and inspections conducted by a Plan, the U.S. Department of Health and Human Services, the Centers for Medicare and Medicaid Services, a State Department of Insurance, the Comptroller General, and all governmental and accrediting agencies to which a Plan is subject. Such cooperation shall include without limitation providing access to any books, contracts, financial records, protected health information, and other records of Provider that pertain to:
- (a) The services performed under this Agreement;
  - (b) Reconciliation and coordination of benefit liabilities;

- (c) Determination of amounts payable;
- (d) Medical audit or review;
- (e) Utilization management and quality improvement;
- (f) Financial transactions associated with this Agreement;
- (g) Overpayment assessments; and
- (h) Other relevant matters as such person conducting the audit, evaluation, or inspection deems necessary.

7.3 Confidentiality of Protected Health Information. Provider shall prepare, maintain, use, and disclose protected health information and other administrative records with respect to Members in accordance with all applicable laws. Such records shall be and remain the property of Provider, and shall be retained as required by applicable law.

7.4 Survival. The Parties agree that this Section 7 shall survive the termination of this Agreement.

## 8. TERM AND TERMINATION

8.1 Initial Term and Renewal. Unless terminated sooner pursuant to this Section 8, the initial term of this Agreement shall be one year, commencing on the Effective Date (Initial Term), and this Agreement shall automatically renew for additional one-year terms upon expiration of the Initial Term.

8.2 Termination Without Cause. Either Party shall have the right to terminate this Agreement without cause at any time upon 90 days advance written notice to the other Party. If Provider fails or refuses to accept an adjusted Payment Rate as set forth in Exhibit I, New Directions shall have the right to terminate this Agreement upon 30 days advance written notice to Provider.

8.3 Termination For Breach. This Agreement may terminate immediately upon the occurrence of any of the following events: (a) either Party notifies the other Party of a material breach of the terms of this Agreement, provided that the allegedly breaching Party shall have 30 days after written notice of such breach to cure the breach; (b) upon the loss of the minimum professional liability insurance coverage for Provider; (c) Provider's suspension from participation in the Medicare or Medicaid program or other government healthcare program; (d) Provider is terminated from, resigns from, fails to timely submit an application or materials for reappointment, or fails to be reappointed to a Provider Network; (e) Provider's professional license or certification to practice is suspended, limited, withdrawn, expired, non-renewed, or revoked; (f) a suspension or revocation of Provider's DEA registration or State drug registration; (g) Provider's conviction of any felony or any offense reasonably related to the qualifications, functions, or duties of Provider, or any offense an essential element of which is fraud, dishonesty,

or violence; or (h) either Party becomes insolvent, or is adjudicated as bankrupt, or its business comes into possession or control of a trustee in bankruptcy, or a receiver is appointed for it, or it makes a general assignment for the benefit of creditors.

- 8.4 **Obligations Following Termination.** In the event of termination of this Agreement, within 15 Business Days of the date of notice of termination, Provider shall supply New Directions with a list of Members currently in treatment with Provider. Provider shall continue providing Covered Services to Members then receiving treatment from Provider in accordance with applicable State law or Plan terms, or until the earliest of: (a) the expiration of such Member's benefits under the Plan; (b) the expiration of a 90-day phase-out period (Phase-Out Period) commencing upon the date of notice of termination of this Agreement; (c) the discharge of such Member by Provider; or (d) the transfer of Member to another Network Provider. If a Member can't be transferred to another Network Provider before the expiration of the Phase-Out Period without having a potential negative effect on Member's condition, then Provider shall continue to provide Covered Services to Member until discharge or a safe transfer is made. Until discharge or transfer of such Member, Provider shall be compensated as specified in Section 4.7 of this Agreement.

## 9. **RELATIONSHIP OF THE PARTIES**

- 9.1 **Independent Contractor Status.** Provider is an independent contractor of New Directions and its Affiliates. Provider and Provider's employees and agents shall in no way be considered agents or representatives of New Directions or any of its Affiliates for any purpose, nor shall Provider or Provider's employees or agents hold themselves out as agents or representatives of New Directions or any of its Affiliates.
- 9.2 **Use of Name and Trademarks.** The Parties each reserve the right to and control of the use of their name, symbols, trademarks, and service marks presently existing or later established. Except as provided herein, neither Party shall use the other Party's name, symbols, trademarks, or service marks in advertising or promotional materials or otherwise without the prior written consent of that Party. Provider agrees that the use of Provider's name, identifying numbers and information, and descriptive material about the Provider's credentials, professional practice, and affiliations may be used in directories, on the New Directions Website, and in other materials and marketing literature of New Directions and its Affiliates.

## 10. **DISPUTES AND DISPUTE RESOLUTION PROCEDURES**

- 10.1 Interim Dispute Process. Upon written notice received from a Party alleging a dispute as to any duty or obligation pursuant to this Agreement, or applicable State or Federal law, the recipient Party, within five business days of receipt of the notice, shall meet or arrange a meeting with the other Party. In the event the Parties can't resolve the dispute at the initial meeting, additional meetings may be scheduled, or the Party providing notice of the dispute may elect to use binding arbitration.
- 10.2 Binding Arbitration. The Parties shall abide by the following procedures for the arbitration process:
- (a) The Party invoking the arbitration process shall send written notice to the other Party setting forth the basis of the dispute and the Party's desire to arbitrate. Arbitration shall be in accordance with the rules and procedures of the American Health Lawyers Association Alternative Dispute Resolution Services or another nationally recognized arbitration association acceptable to the Parties.
  - (b) Arbitration shall be conducted in a mutually agreed upon location and before a single arbitrator agreed upon by the Parties, or if no agreement, by a panel of three arbitrators. Each Party shall select one arbitrator and the third arbitrator shall be selected by those two arbitrators.
  - (c) The arbitrator may not award consequential, special, punitive, or exemplary damages. The arbitrator may award costs, including reasonable attorneys' fees, against a Party. If the decision of the arbitrator doesn't include such award, the Parties shall equally share the costs of the arbitration.
  - (d) This Section 10.2 doesn't limit the ability of either Party to such temporary or preliminary injunctive relief against the other Party in a court of competent jurisdiction.
  - (e) The decision of the arbitrator shall be final and binding on the parties and enforceable under the laws of the State of Missouri.
- 10.3 Survival. The Parties agree that this Section 10 shall survive the termination of this Agreement.

## 11. MISCELLANEOUS

- 11.1 Amendments. No changes, alterations, or amendments to this Agreement shall be effective unless signed by both Parties. Notwithstanding the foregoing, at New Directions' discretion, New Directions may unilaterally amend this Agreement upon written notice to Provider to comply with any applicable law or order or directive of any governmental agency.



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

**INTENDING TO BE LEGALLY BOUND**, the undersigned Parties have executed this Agreement.

New Directions Behavioral Health, LLC:

Provider:

By: \_\_\_\_\_

By: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Title: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_

**NEW DIRECTIONS BEHAVIORAL HEALTH, LLC**

**AMENDMENT TO PROVIDER AGREEMENT  
INCLUDING EXHIBIT 2**

The Provider Agreement entered into between New Directions Behavioral Health, LLC, on behalf of itself and its Affiliates (New Directions) and \_\_\_\_\_ (Provider) on \_\_\_\_\_, 2011 is hereby amended as follows:

Section 1.5 is revised to read:

“Covered Services. Covered Services means those Medically Necessary services and supplies which are within Provider’s professional license or certification and scope of practice and competency and which a Member is entitled to receive payment for under the terms and conditions of the Member’s Plan. “

Section 2.9 is revised to read:

“Determining Medical Necessity. In the event New Directions determines that a service is not Medically Necessary, Provider may appeal the determination in accordance with New Directions’ grievance policy and applicable law.”

Section 4.9 is revised to read:

“Overpayments and Underpayments” Overpayment and underpayments shall be processed in accordance with laws, as applicable, and in accordance with New Directions’ and Payor’s policies and procedures.”

Section 7.3 is revised to read:

.... Such records shall be and remain the property of Provider, and shall be retained as required by applicable law.

Section 11.3 is revised to read:

“Governing Law.” This Agreement shall be governed in all respects by the laws of the State of Florida without regard to its choice-of-law provisions such that Florida law shall apply and govern in all respects as to all issues and disputes.”

Exhibit 2 of the Provider Agreement is revised as follows:

Section 2.3 is revised to read:

“Provider shall provide Covered Services with the informed consent of BCBSF and HOI Members.”

Section 3.2 is revised to read:

“Provider agrees to make available during normal business hours Provider’s premises, physical facilities, equipment, records relating to BCBSF and HOI Members, and any additional relevant information required in conjunction with any audit, evaluation, or inspection.”

Section 4.5 is deleted.

Sections 5.1 and 5.2 are deleted.

Section 7.2 is revised to read:

“Except in the case of emergency medical condition or when approved by New Directions, Provider shall not refer a BCBSF or HOI Member to a non-Network Provider except as necessary or permitted under the Member’s benefits agreement, or as necessary for the emergency medical condition or medical condition or care.”

Section 7.6 is revised to read:

“Upon termination of this Provider Agreement, Provider shall not bill or otherwise seek compensation from Payor under the terms of this Provider Agreement for the provision of Covered Services to BCBSF or HOI Members that occur after termination of this Provider Agreement, except as specified in Section 9, including billing under another Network Provider’s name or billing identification number.”

Section 7.7 is deleted.

**THIS AMENDMENT IS EFFECTIVE AS OF AUGUST 24, 2011.**

**INTENDING TO BE LEGALLY BOUND**, the undersigned Parties have executed this Agreement.

New Directions Behavioral Health, LLC:

Provider:

By: \_\_\_\_\_

By: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Title: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_



# NEW DIRECTIONS BEHAVIORAL HEALTH, LLC

## FLORIDA PROVIDER AGREEMENT

### EXHIBIT 2

#### BLUE CROSS AND BLUE SHIELD OF FLORIDA, INC. AND HEALTH OPTIONS, INC.

The following terms and conditions shall apply in addition to those set forth in this Florida Provider Agreement if Provider provides Covered Services to Members in the Blue Cross and Blue Shield of Florida, Inc. and/or Health Options, Inc. health plans (includes all products). To the extent that the terms and conditions of this Exhibit 2 conflict with the terms and conditions set forth in the Florida Provider Agreement, the terms and conditions of this Exhibit 2 shall govern:

#### 1. PROVIDER'S EMPLOYEES

- 1.1 Provider shall not allow any employee who is on the Inspector General of the Department of Health and Human Services (OIG) list of excluded individuals/entities (LEIE), or the U.S. General Services Administration (GSA) list of individuals and entities list system (EPLS) to be involved in providing Covered Services, directly or indirectly, to Members in the Blue Cross and Blue Shield of Florida, Inc. health plan (BCBSF) or Members in the Health Options, Inc. health plan (HOI).
- 1.2 Provider shall verify that all of Provider's employees who directly or indirectly provide Covered Services to BCBSF or HOI.
  - (a) Are competent to do so;
  - (b) Possess any and all licenses, permits, certifications, and such other regulatory approvals required by law to perform such Covered Services;
  - (c) Perform only those Covered Services that they are legally authorized and permitted to perform; and
  - (d) Perform their duties in providing Covered Services in accordance with all laws, applicable national, state, and county standards of professional ethics and practice, and any applicable accreditation or regulatory requirements.
- 1.3 Provider is encouraged to provide staff who are proficient in English and Spanish.

#### 2. REPRESENTATIONS OF PROVIDER

- 2.1 Provider shall provide Covered Services to BCBSF and HOI Members to the same extent and in the same manner that Provider treats other patients.
- 2.2 Provider shall provide Covered Services to BCBSF and HOI Members in accordance with accepted professional and ethical standards of patients.

- 2.3 Provider shall provide Covered Services with the informed consent of BCBSF and HOI Members.
- 2.4 Covered Services shall only be provided by qualified health personnel.
- 2.5 Provider agrees to cooperate with any grievance and appeal resolution process for BCBSF and HOI Members, and to comply with all final determinations as applicable.
- 2.6 Provider acknowledges that BCBSF and HOI Members have the following rights:
  - (a) To be treated with respect and recognition of their dignity and need for privacy; and
  - (b) To voice complaints or appeals about New Directions, Provider, or the care provided.
- 2.7 Provider understands and agrees that all marketing materials used to market to BCBSF and HOI Members must be submitted to New Directions for review and approval prior to distribution.
- 2.8 Provider shall make best efforts to participate in, implement, and fully utilize electronic technology which is compatible with BCBSF and HOI claims processing and eligibility systems.
- 2.9. Provider shall make best efforts to be prepared to implement and transition to ICD-10 in the required timeframes set by laws.
- 2.10 Provider shall provide, properly service and maintain, in good working order and otherwise appropriate, facilities, equipment, goods, and supplies to provide Covered Services to BCBSF and HOI Members.
- 2.11 Provider shall indemnify and hold harmless BCBSF and HOI from and against any claim, cause of action, liability, damage, cost or expense, including attorneys' fees and court or proceeding costs, arising out of or in connection with the following when it involves or pertains to a BCBSF or HOI Member:
  - (a) Any act or omission by Provider, or by any officer, director, employee, agent, subcontractor, or representative of Provider;
  - (b) Any Covered Service furnished by Provider; and
  - (c) Any use or disclosure of information collected from or about BCBSF and HOI Members.

### 3. AUDITS, EVALUATIONS, AND INSPECTIONS

- 3.1 Section 7.2 of this Florida Provider Agreement is expanded by including Florida Agency for Health Care Administration (AHCA), Florida Comptroller General, Federal Employees Program Director's Office (FEPDO), and Office of Personnel Management (OPM) as entities with which Provider shall cooperate and comply.
- 3.2 Provider agrees to make available during normal business hours Provider's premises, physical facilities, equipment, records relating to BCBSF and HOI Members, and any additional relevant information required in conjunction with any audit, evaluation, or inspection.

- 3.3 Provider agrees to provide any requested financial statements or other financial information as requested by the Florida Office of Insurance (OIR) or AHCA, or by New Directions when requested by the OIR or AHCA.

4. COMPLIANCE PROGRAM

- 4.1 Provider shall report any compliance violations, including any suspected or confirmed fraud or abuse, related to BCBSF and HOI Members to New Directions within ten (10) business days of discovering such violation.
- 4.2 Provider shall cooperate in any investigation related to suspected or confirmed misconduct, compliance violation, fraud, or abuse directly or indirectly related to the provision of Covered Services to BCBSF and HOI Members.
- 4.3 Provider agrees to not retaliate against any individual who reports, in good faith, violations of Provider's compliance program or policies, including suspected fraud or abuse.

5. DATA AND INFORMATION

- 5.1 In addition to the information referenced in Section 9.2 of this Provider Agreement, Provider agrees to provide to and allow New Directions and BCBSF and HOI to use and to release data and information pertaining to Provider reasonably deemed to be relevant and important for their purpose including, without limitation:
  - (a) Information and data submitted or collected in conjunction with participation in the Provider Network;
  - (b) Survey data;
  - (c) Utilization information;
  - (d) Quality of care measures and initiatives;
  - (e) Service volumes;
  - (f) Credentialing information;
  - (g) Outcome measures;
  - (h) BCBSF and HOI Member satisfaction results;
  - (i) Accessibility and overall satisfaction with encounter experiences;
  - (j) Cost data; and
  - (k) Such other health care related data generated or collected in connection with providing Covered Services to BCBSF and HOI Members (Health Care Data).
- 5.2 Provider agrees that Health Care Data may be used and released as permitted by law for any purpose including, without limitation, allowing BCBSF and HOI Members, employer groups, and others to relatively compare the cost and level of quality of care.
- 5.3 Provider shall notify New Directions immediately if any Health Care Data used or released is materially inaccurate.

6. PROVISION OF SERVICES

- 6.1 In addition to those requirements set forth in Section 2 of this Florida Provider Agreement, Provider agrees to provide Covered Services to BCBSF and HOI Members in the most cost-efficient setting, consistent with sound clinical judgment and including, without limitation, the following:
- (a) Using standards and rules of ethics and conduct and other guidelines promulgated and issued by the organizations applicable to Provider and the licensing entity and regulatory authority to which Provider is subject to for licensing and control;
  - (b) Identifying BCBSF and HOI Members with complex or serious medical and/or behavioral health conditions for potential eligibility for case management or disease management;
  - (c) Participating in access surveys;
  - (d) Displaying, if requested, in a visible and prominent place any reasonable card, plaque, or similar identifying logo to identify Provider to BCBSF and HOI Members; and
  - (e) Complying fully with New Directions policies, procedures, and programs including, without limitation:
    - (i) Peer review;
    - (ii) Case management;
    - (iii) Treatment plans and documentation requirements, including for complex and serious conditions, targeted conditions, and chronic conditions;
    - (iv) Provider performance evaluation;
    - (v) Demographic information collection;
    - (vi) Disease management;
    - (vii) Wellness;
    - (viii) Care coordination;
    - (ix) Medical coverage guidelines;
    - (x) Discharge planning;
    - (xi) Credentialing and recredentialing;
    - (xii) Medical management;
    - (xiii) On-site reviews; and
    - (xiv) Advance directives.
- 6.2 Except in the case of an emergency medical condition or when approved by New Directions, Provider shall not refer a BCBSF or HOI Member to a non-Network Provider except as necessary or permitted under the Member's benefits agreement, or as necessary for the emergency medical condition or medical condition or care.
- 6.3 If Provider's performance of Covered Services to BCBSF or HOI Members results in an issue of non-compliance with State or regulatory agencies, Provider shall be financially responsible for such non-compliance.
- 6.4 Provider shall abide by all applicable laws when treating BCBSF and HOI Members with disabilities including, without limitation, providing effective communications regarding treatment options.

- 6.5 Prior to the provision of the health care services that are not Covered Services (non-Covered Services), Provider shall inform the BCBSF or HOI Member and obtain the Member's written acknowledgement that the Provider has informed the Member:
- (a) Of the nature of the non-Covered Services;
  - (b) An explanation of why the non-Covered Services shall not be covered; and
  - (c) That the BCBSF or HOI Member shall be personally and financially liable for payment of such non-Covered Services, which can be billed to the Member at the Provider's usual and customary charge.
- 6.6 Upon termination of this Florida Provider Agreement, Provider shall not bill or otherwise seek compensation from Payor under the terms of this Provider Agreement for the provision of Covered Services to BCBSF or HOI Members that occur after termination of this Florida Provider Agreement, except as specified in Section 8, including billing under another Network Provider's name or billing identification number.

7. NOTICES AND REPORTING

- 7.1 Section 5.3 of this Florida Provider Agreement is hereby modified by these notice requirements:
- (a) Within one (1) business day Provider shall notify New Directions if:
    - (i) Provider's license is limited, restricted, revoked, or otherwise terminated;
    - (ii) Any action is taken by the State of Florida or any other regulatory body that would materially impair the ability of Provider to provide or arrange for Covered Services to BCBSF or HOI Members;
    - (iii) Provider is materially sanctioned by a government entity; or
    - (iv) Provider's eligibility to participate in Medicare or Medicaid is suspended, limited, restricted, or otherwise terminated; and
  - (b) Within five (5) business days Provider shall notify New Directions if:
    - (i) Provider is required to pay damages in any professional liability action by way of settlement or judgment related to Covered Services provided to a BCBSF or HOI Member; or
    - (ii) Provider receives a notice of intent to file or actual filing of any professional liability action against Provider, or against an entity in which Provider has an ownership interest other than a publicly traded company, that involves a BCBSF or HOI Member and Covered Services provided by Provider.
- 7.2 Provider shall notify New Directions when Provider begins or ceases to accept new BCBSF or HOI Members.

8. CONTINUATION OF CARE

- 8.1 Upon termination of this Florida Provider Agreement, in addition to the obligations set forth in Section 8.4 of the Florida Provider Agreement, Provider agrees to cooperate with New Directions and BCBSF and HOI by taking reasonably and clinically appropriate measures for the timely transition of BCBSF and HOI Members, including providing any information and taking actions as reasonably requested to effectuate an orderly and systematic transition of BCBSF and HOI Members.
- 8.2 The provisions of Section 8.4 of this Florida Provider Agreement and Section 8 of this Exhibit 2 shall survive the termination of the Florida Provider Agreement for ninety (90) calendar days.