LETTER AGREEMENT

This letter shall serve as a Letter Agreement ("Letter") between Managed Health Services Insurance Corp. ("Plan") and Milwaukee Fire Department ("Provider"), with respect to Provider's provision of covered services ("Covered Services") by Provider and/or its hospitals, physicians, other healthcare professionals, and ancillaries, or any combination thereof, as appropriate and if applicable (collectively referred to herein as "Participating Providers"), to individuals ("Covered Persons") enrolled with the Plan pursuant to its contract with the _____ Program ("Medicaid") in the state of Wisconsin ("State"). Participating Providers are set forth on Exhibit 2 of this Letter (attached and incorporated by reference). The parties agree as follows:

1. **Provision of Services and Claims Submission**. Participating Providers agree to provide Covered Services to Covered Persons. Participating Providers shall submit to Plan all Clean Claims, as defined by the contract between Plan and the Medicaid, for Covered Services payable according to the Compensation Schedule set forth in Exhibit 1 (attached and incorporated by reference) within ninety (90) days. Participating Providers shall submit all claims in accordance with the Provider Manual. The Provider Manual shall mean the Plan's manual of policies, procedures and requirements to be followed by providers participating in the Plan's network; the Provider Manual may be changed from time to time by Plan.

2. **Compensation**. Plan shall compensate Participating Providers for all Covered Services provided to Covered Persons during the term of this Letter in accordance with the Compensation Schedule set forth in Exhibit 1.

3. **Covered Person Hold Harmless**. Participating Providers expressly agrees that in no event, including but not limited to nonpayment by Plan, Plan insolvency or breach of this Letter, shall Participating Providers bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Covered Person, or any person (other than Plan) acting on such Covered Person's behalf, for Covered Services provided under this Letter. This provision shall not prohibit the collection of any applicable copayments or other amounts that are the Covered Person's financial responsibility. Participating Providers further agree that: (a) this provision shall survive the termination of this Letter; and (b) this provision supersedes any oral or written contrary agreement now existing or hereinafter entered into between Participating Providers and any Covered Person or any person acting on such Covered Person's behalf.

4. **Term and Termination**. This Letter shall commence as of _____ ("Effective Date") and shall terminate on the earlier of: (i) a formal written agreement; or (ii) unless sooner terminated as provided for herein. This Letter may be terminated for cause immediately upon written notice, if there is imminent harm to patient health or if fraud or malfeasance is suspected. This Letter may also be terminated if either party is in breach of a material provision of this Letter and fails to cure such material breach prior to the expiration of a thirty (30) day written notice and cure period. This Letter may be terminated without cause by either party, at any time, upon ninety (90) days written notice to the other party. Any termination pursuant to the terms of this Letter shall be subject to the requirements of applicable law, including but not limited to continuity of care requirements.

   Notwithstanding the foregoing, the parties acknowledge that they are in the process of negotiating the terms of a formal written agreement relative to the provision of Covered Services to Covered Persons. Once executed, the terms of the formal provider agreement will supersede the provisions of this Letter, provided that the "hold harmless" provisions of Section 3 and "dispute resolution and arbitration" provisions of Section 8 will survive the termination of this Letter.

5. **Formal Written Agreement**. The parties agree that they shall make best efforts to execute a formal written agreement within six (6) months following execution of this Letter. The formal written agreement shall include a minimum three (3) year term.

6. **Qualifications and Credentialing Criteria**. Participating Providers agree that Participating Providers hold all necessary licenses, registrations and/or certifications required under State or federal law to provide the services contracted for hereunder and shall at all times meet, maintain and adhere to the policies and procedures of Plan, including but not limited to (1) those relating to licensure, certification and accreditation; (2) certification to participate in any federal or State health care program including but not limited to the Medicare and Medicaid programs; (3) the Provider Manual; and (4) Plan's and National Committee for Quality Assurance's credentialing policies and requirements, utilization management/quality assurance programs and policies (including requirements for review of Participating Providers' services by Plan personnel and committees), complaint/appeal policies, and administrative policies such as those (by way of example but not limitation) relating to claims submission, coordination of benefits, and coverage verification (collectively, any and all Plan policies, procedures, programs and requirements shall be referred to as "Plan Policy(ies)"). Participating Providers shall give immediate notice to Plan of any event that causes Participating Providers to be out of compliance with its ability to fulfill its obligations under this Letter, or of any change in Participating Providers' name, ownership, control, or taxpayer identification number.

7. **Compliance with Laws**. Participating Providers shall at all times adhere to, and comply with, all applicable laws and regulations, including but not limited to those laws and regulations related to the Medicaid program with respect to Covered Persons. This Letter is subject to all State and federal laws and regulations relating to fraud and abuse in health care and the Medicaid program. Participating Providers agree to comply with the applicable terms of the Medicaid. During the term of this Letter, the Parties understand and agree that it will be automatically amended to conform with State and federal requirements as set forth in this Section.

8. **Dispute Resolution and Arbitration**. Any controversy or claim between the parties arising out of, or relating to, this Letter ("Dispute") shall first be resolved through the grievance procedures outlined in the Plan's Provider Manual. In the event the grievance procedures are exhausted without resolution, then the Dispute shall be submitted to 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 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"). Notwithstanding the foregoing, in no event may any arbitration be initiated more than one (1) year following the remittance of written notice by either party of the Dispute pursuant to the grievance procedures set forth in the Plan's Provider Manual. Any arbitration proceeding under this Letter shall be conducted in a location as specified by Plan. The arbitrators shall have no right to award any punitive or exemplary damages or to vary or ignore the terms of this Letter 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 Letter. Notwithstanding any dispute arising under this Letter, each party hereto shall continue to perform its obligations hereunder pending the decision of the arbitrator. This provision shall survive any termination of this Letter.

9. **Records and Confidentiality**. Participating Providers shall maintain detailed medical, financial and administrative records concerning Covered Services provided to Covered Persons under this Letter. Such records shall be retained by Participating Providers for the period of time required by all applicable laws or regulations, but in no event less than the later of seven (7) years from the date the service was rendered or termination of this Letter. Participating Providers agree that Plan, as well as authorized State and federal agencies, shall have the right to review records related to services rendered to Covered Persons, and Participating Providers agree to cooperate with Plan and any State or federal agency in making available, and in arranging or allowing inspection of, such records as may be: (i) necessary to verify Participating Providers compliance with the terms of this Letter or the appropriateness of any payments hereunder; (ii) required under State or federal law or regulation; or (iii) appropriate to disclose to regulatory authorities or Plan in connection with their/its assessment of quality of care or investigation of Covered Person

grievances or complaints. Further, Participating Providers agree to obtain any necessary releases from Covered Persons with respect to their records and the information contained therein to permit Plan and/or State and federal agencies, access to such records. Plan and Participating Providers agree that each Covered Person's medical records shall be treated as confidential so as to comply with all State and federal laws and regulations regarding the confidentiality of patient records. Subject to the foregoing, Participating Providers shall supply State and federal agencies with copies of Covered Person's medical records upon request at no charge. Participating Providers shall participate in any system established by Plan to facilitate the sharing of records as appropriate with providers involved in the Covered Person's care in order to facilitate the provision of a coordinated and seamless continuum of care, subject to applicable confidentiality requirements. Participating Providers agree to cooperate in the transfer of Covered Person's medical records to other providers, to assume any cost associated therewith, and shall use best efforts to transfer any medical records in Participating Providers' custody within ten (10) days of a Covered Person's request.

10. **Confidentiality of Letter**. The parties acknowledge and agree that the terms of this Letter are confidential and shall not be disclosed to any third party without the non-disclosing party's prior written consent, except where such disclosure is required by applicable law.

I believe that this Letter accurately reflects the terms of our agreement. If you concur, please have the individual with appropriate authority execute both originals of this Letter in the Acknowledgement space provided below, and return one fully executed original of this Letter to me by _____.

Sincerely,

_____

Acknowledgement: Provider concurs with, and agrees to be bound by, the terms and conditions outlined in the Letter as evidenced by the signature of its authorized agent or officer as set forth below. To the extent applicable, Provider hereby represents and warrants that it has the legal authority to enter into this Letter on behalf of and to bind each Participating Provider, as well as any and all persons providing services hereunder on Participating Providers' behalf, to the terms and conditions hereof. Provider further represents and warrants that all Participating Providers, and persons providing services hereunder on Participating Provider's behalf, are bound to the terms of this Letter.

Signed: _____

Print: _____

Title: _____

Date: _____

IN WITNESS WHEREOF, the Parties hereto have executed this Agreement effective as of the date first above written.

Health Plan:

_____

Authorized Signature

_____

Printed Name: _____

Title: _____

Signature Date: _____

Provider:

_____

Authorized Signature

_____

Printed Name: _____

Title: _____

Signature Date: _____

Tax Identification Number: _____
National Provider Identifier: _____

State Medicaid Number: _____

Attachment A: Medicaid

SCHEDULE A
STATE-MANDATED PROVISIONS FOR BADGERCARE PLUS AND MEDICAID SSI

Health Plan and Milwaukee Fire Department ("Provider") shall comply with the following provisions, which are required by State law to be included in this Agreement, as such provisions may be amended from time to time by the State.

1. As used in this Agreement, the term "State" refers to the State of Wisconsin.

2. Covered Person Hold Harmless. Except as provided below, Provider shall look only to the applicable Payor for payment for all Covered Services to Covered Persons provided under this Agreement, and agrees to hold Covered Persons harmless for compensation for same. Under no circumstances, including, but not limited to, non-payment by Payor, Payor insolvency, or breach of this Agreement or an Attachment, shall Provider, or any of his/her assignees or subcontractors, bill, charge, collect or deposit from, or seek compensation, remuneration or reimbursement from, or have any cause of action against, Covered Persons or other persons or entities (other than Health Plan) acting on a Covered Person's behalf for the services provided pursuant to this Agreement. Provider further agrees to include in any subcontracts that Provider enters into for the purposes of performing Provider's obligations under this Agreement that such subcontractor must hold Covered Persons harmless in accordance with this section. This provision shall not prohibit Provider from collecting copayments in accordance with the Covered Services. This provision shall survive the termination of this Agreement or any Attachment and shall be for the benefit of Covered Persons, inure to the benefit of Covered Persons and supersede any oral or written agreement now existing or hereinafter entered into between Provider and any Covered Person (or any such person acting on the Covered Person's behalf). Any modifications, additions, or deletions to this provision shall be effective no earlier than thirty (30) days after the State agency for BadgerCare Plus and Medicaid SSI has received written notice of and approved such changes. Provider may charge, bill and collect from a Covered Person for health services that are not Covered Services only if, prior to providing such services, the Covered Person signs a waiver in a form acceptable to Health Plan and the applicable Payor acknowledging that such specific Covered Services are not authorized for reimbursement by the Payor and that the Covered Person will pay all charges for such services. Neither Health Plan nor a Payor shall have any obligation to pay Provider any portion of any charges for any health services that are not Covered Services.

3. Rights and Obligations of the Parties Upon Termination. Regardless of the reason for termination of this Agreement, Provider shall continue to provide Covered Services to any affected Covered Person who is an inpatient on the date of termination until discharge, in accordance with sound medical practice. Provider further agrees that Article VII shall apply to all continued care, and that the provisions of this section shall survive the termination of this Agreement or any Attachment and shall be construed to be for the benefit of Covered Persons. Provider may have continued responsibility for providing Covered Services to Covered Persons in circumstances not specifically set forth above and, in such circumstances, requirements of State and/or Federal Law will govern the furnishing of such continuing care after this Agreement and/or any Attachment terminates.

4. Covered Person's Rights Upon Termination. Upon the request of a Covered Person, Provider shall continue to treat the Covered Person for up to sixty (60) days or longer as needed in order to be in compliance with the State's continuity of care guidelines, following the effective date of termination of this Agreement. During such period, all the terms and conditions of this Agreement shall remain in force as they relate to the Covered Person(s) in question.

Attachment A: Medicaid

SCHEDULE A-1
BADGERCARE PLUS AND MEDICAID SSI PRODUCT ATTACHMENT
(INCLUDING REGULATORY REQUIREMENTS AND COMPENSATION SCHEDULE)

This Schedule is incorporated into the Participating Provider Agreement (the "Agreement") entered into by and between Health Plan and Milwaukee Fire Department ("Provider"). This Schedule is effective _____ (the "Effective Date").

I. RECITALS. Provider has entered into the Agreement with Health Plan. This Schedule is intended to supplement the Agreement by setting forth the parties' rights and responsibilities related to the provision of Covered Services to Covered Persons who are eligible under the State BadgerCare Plus and Medicaid SSI program.

II. DEFINITIONS APPLICABLE TO THIS PRODUCT. The following terms, and any terms defined in the Agreement, shall have the specified meanings when capitalized in this Schedule:

A. Covered Services means those health and medical services that are payable under the terms of the State BadgerCare Plus and Medicaid SSI Contract and that are provided in accordance with the terms of this Agreement.

B. Emergency Care means care sought by a Covered Person for a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such 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:

(1) 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;
(2) serious impairment of bodily functions;
(3) serious dysfunction of a bodily organ or part;
(4) with respect to a pregnant woman who is in active labor:

a) that there is inadequate time to effect a safe transfer to another Hospital before delivery; or
b) that transfer may pose a threat to the health or safety of the woman or the unborn child.

(5) a psychiatric emergency involving a significant risk of serious harm to oneself or others;
(6) significant risk of serious harm to a Covered Person or others, due to substance abuse and a likelihood of return to substance abuse without immediate treatment; or
(7) pain, an acute infection, swelling, trismus, fever, or trauma due to a dental emergency.

C. BadgerCare Plus and Medicaid SSI Contract means any agreement then in effect between State and Health Plan or another managed care organization for which Health Plan is a subcontractor, as revised or replaced from time to time (including, but not limited to, the BadgerCare Plus and Medicaid SSI Contract awarded to Health Plan pursuant to the State BadgerCare Plus and Medicaid SSI managed care program as implemented by the State from time to time) pertaining to the provision of services by Health Plan to Covered Persons who are beneficiaries of the State BadgerCare Plus and Medicaid SSI program and who enroll to receive care through Health Plan.

D. BadgerCare Plus and Medicaid SSI Covered Person is an individual BadgerCare Plus or Medicaid SSI beneficiary who is eligible and has enrolled or been assigned to receive Covered Services from Health Plan pursuant to the terms of the BadgerCare Plus and Medicaid SSI Contract.

E. State BadgerCare Plus and Medicaid SSI Agency means the Wisconsin Department of Health Services, which administers the State BadgerCare Plus and Medicaid SSI managed care program, as implemented from time to time.

III. REIMBURSEMENT. For all Covered Services provided by Provider, which constitute Covered Provider Services, Health Plan will pay Provider in accordance with the Compensation Schedule annexed as Exhibit to this Product Attachment to Agreement.

IV. COMPLIANCE WITH STATE BADGERCARE PLUS AND MEDICAID SSI AGENCY REQUIREMENTS.

A. Provider agrees to comply with applicable State BadgerCare Plus and Medicaid SSI Agency Requirements, (the "Requirements") including, without limitation, requirements set forth in the BadgerCare Plus and Medicaid SSI Contract related to participation in quality improvement and grievance resolution procedures and mandated covered benefits. Provider acknowledges that the State BadgerCare Plus and Medicaid SSI Agency may change such Requirements ("New Requirements") and agrees to comply with any such New Requirements affecting its rights or obligations pursuant to this Attachment upon its receipt of notice of any such Requirements from Health Plan. Provider shall comply with the terms of Schedule A to this Product Attachment.

B. In addition to complying with the record keeping and review requirements set forth in the Agreement, Provider agrees to release any information requested by Health Plan as may be reasonably necessary to comply with Health Plan's obligations to provide information to the State BadgerCare Plus and Medicaid SSI Agency pursuant to the BadgerCare Plus and Medicaid SSI Contract. Provider agrees to establish and maintain procedures and controls so that no information contained in records obtained from the State BadgerCare Plus and Medicaid SSI Agency or from others in carrying out the terms of this Attachment shall be used by or disclosed by Provider or employees except as provided in Section 1106 of the Social Security Act and regulations prescribed thereunder.

C. Provider further agrees to provide Health Plan and the State BadgerCare Plus and Medicaid SSI Agency with full and complete ownership and control information, upon request, as required by 42 CFR 420.

D. Provider represents and warrants that it is eligible to participate in the BadgerCare Plus and Medicaid SSI program. Provider shall promptly notify Health Plan of any suspension or termination of participation in the Medicaid program of any state. Health Plan shall be entitled to immediately terminate this Attachment in such circumstances.

E. This Attachment shall be contingent upon the approval of its terms by the State BadgerCare Plus and Medicaid SSI Agency, and any other necessary governmental agency (as applicable). This Attachment shall terminate upon the termination of all BadgerCare Plus and Medicaid SSI Contracts held by Health Plan.

V. NO OTHER CHANGES. Other than as set forth above, this Attachment shall not alter any of the terms or conditions of the Agreement, all of which shall remain in full force and effect.

Attachment A: Medicaid

SCHEDULE B
PRODUCT ATTACHMENT ADDENDUM
BADGERCARE PLUS AND MEDICAID SSI ENROLLEES

Addendum for the Provision of Services for BadgerCare Plus and Medicaid SSI Enrollees.

In providing care for the BadgerCare Plus and Medicaid SSI enrollees served by Managed Health Services, both those enrolled by direct contract with the Department of Health Services, as well as those through subcontract with other Health Plans, Provider agrees to the following.

Provider (hereafter identified as "Subcontractor") agrees to abide by all applicable provisions of the Health Plans' contract with the Department of Health Services, hereafter referred to as the BadgerCare Plus and Medicaid SSI Health Plan Contract. Subcontractor compliance with the BadgerCare Plus and Medicaid SSI Health Plan Contract specifically includes, but is not limited to, the following requirements:

1. Subcontractor uses only BadgerCare Plus and/or Medicaid SSI-certified providers in accordance with this Contract.

2. No terms of this subcontract are valid which terminate legal liability of the Health Plan.

3. Subcontractor agrees to participate in and contribute required data to Health Plan Quality Assessment/Performance Improvement programs.

4. Subcontractor agrees to abide by the terms of this Contract for the timely provision of emergency and urgent care. Where applicable, subcontractor agrees to follow those procedures for handling urgent and emergency care cases stipulated in any required hospital/emergency room MOUs signed by the Health Plan in accordance with this Contract.

5. Subcontractor agrees to submit Health Plan encounter data in the format specified by the Health Plan, so that the Health Plan can meet the Department specifications required by this Contract. The Health Plan will evaluate the credibility of data obtained from subcontracted vendors' external databases to ensure that any patient-reported information has been adequately verified.

6. Subcontractor agrees to comply with all non-discrimination requirements.

7. Subcontractor agrees to comply with all record retention requirements and, where applicable, the special compliance requirements on abortions, sterilizations, hysterectomies, and HealthCheck reporting requirements.

8. Subcontractor agrees to provide representatives of the Health Plan, as well as duly authorized agents or representatives of the Department and the federal Department of Health and Human Services, access to its premises and its contracts, medical records, billing, including contractual rates agreed upon between the Health Plan and the subcontractor, and administrative records. Refusal will result in sanctions or penalties in Article XI against the Health Plan for failure of its subcontractor to permit access to a Department or federal DHHS representative. Subcontractor agrees otherwise to preserve the full confidentiality of medical records in accordance with this Contract.

9. Subcontractor agrees to the requirements for maintenance and transfer of medical records stipulated in this Contract.

10. Subcontractor agrees to ensure confidentiality of family planning services.

11. Subcontractor agrees not to create barriers to access to care by imposing requirements on members that are inconsistent with the provision of medically necessary and covered BadgerCare Plus and/or Medicaid SSI benefits (e.g., COB recovery procedures that delay or prevent care).

12. Subcontractor agrees to clearly specify referral approval requirements to its providers and in any sub-subcontracts.

13. Subcontractor agrees not to bill BadgerCare Plus and/or Medicaid SSI members for medically necessary services covered under this Contract and provided during the members' period of Health Plan enrollment. Subcontractor also agrees not to bill members for any missed appointments while the members are eligible under the BadgerCare Plus and/or Medicaid SSI Programs. This provision will remain in effect even if the Health Plan becomes insolvent. However, if a member agrees in writing to pay for a non-covered service, then the Health Plan, Health Plan provider, or Health Plan subcontractor can bill.

    The standard release form signed by the member at the time of services does not relieve the Health Plan and its providers and subcontractors from the prohibition against billing a BadgerCare Plus or Medicaid SSI member in the absence of a knowing assumption of liability for a non-covered service. The form or other type of acknowledgment relevant to BadgerCare Plus or Medicaid SSI member liability must specifically state the admissions, services, or procedures that are not covered by BadgerCare Plus or Medicaid SSI.

14. Within 15 business days of the Health Plan's request, subcontractors must forward medical records pursuant to grievances to the Health Plan. If the subcontractor does not meet the 15 business day requirement, the subcontractor must explain why and indicate when the medical records will be provided.

15. Subcontractor agrees to abide by the terms regarding appeals to the Health Plan and to the Department regarding the Health Plan's nonpayment for services providers render to members.

16. Subcontractor agrees to abide by the Health Plan marketing/informing requirements. Subcontractor will forward to the Health Plan for prior approval all flyers, brochures, letters and pamphlets the subcontractor intends to distribute to its members concerning its Health Plan affiliation(s), or changes in affiliation, or relating directly to the BadgerCare Plus and/or Medicaid SSI population. Subcontractor will not distribute any "marketing" or member informing materials without the consent of the Health Plan and the Department.

17. Subcontractor agrees to abide by the Health Plan's restraint policy, which must be provided by the Health Plan. Members have the right to be free from any form of restraint or seclusion used as a means of force, control, ease or reprisal.

LETTER AGREEMENT
PRODUCT ATTACHMENT A
COMPENSATION SCHEDULE
MEDICAID

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

Additional Provisions:

1. Program Overview: Milwaukee Fire Department (MFD) has created a care coordination program, Mobile Integrated Health Program (MIHP) designed to improve the quality, access and cost managed of care to Milwaukee's most underserved populations. Managed Health Services (MHS) has agreed to identify it's high-risk members located in Milwaukee County that have not been receptive to traditional managed care case management programs; MFD MIHP has agreed to enter into a binding agreement to address these healthcare challenges by deploying field based Fire Department Professionals that will locate, educate, and provide additional services that improve the quality of care. Once MFD locates the member, the program schedules 4 separate meetings with the member intended to close care gaps and improve the quality of life of the member; Home Safety Visit (Visit 1), Medication Assessment(Visit 2), MFD & Onsite Pharmacist education(Visit 3), and MHS/MFD Joint Member Meeting(Visit 4). Successful outcome of the program will result in improved closure of member's care gaps, reduced preventable Emergency Department admission, provide immunizations, reconciliation of prescribed medications, improved member communication with MHS Case Manager, improved member satisfaction with MHS, among others.

2. Subject to the terms and conditions set forth in the Agreement, MHS will provide MFD the information specified in this Letter of Agreement.

3. MHS to Provide 25 Childless Adults members in which MFD will attempt to successfully engage and enroll 15 of the 25 members in the MIHP; in the event there is an immediate disqualifier, such as, the member no longer lives in the city of Milwaukee or is deceased, to replace said member with another candidate that shall not exceed 15.

4. Program Costs: MHS shall be responsible for the payment of members actively enrolled and managed by MIHP and MFD shall invoice monthly;
$600 per member search fee and $150 per visit (maximum 4 visits) for MFD care coordination program. The Member Search Fee is fixed amount paid after successful outreach of members enrolled in the MIHP, MHS will not be responsible for member search costs related to unidentified members.

a. The maximum cost per enrolled member shall not exceed $1,200
b. The maximum total program cost for 15 enrolled members shall not to exceed $18,000.

5. MHS and MFD shall meet monthly to review cases and determine potential next steps for improved engagement.

6. MFD to Provide (MHS) with a Patient Outcomes Report for each member engaged in the Mobile Integrated Healthcare Program (MIHP) along with detailed notes related to each member visit.