Transportation Provider Manual
V4.3

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Manual Purpose

The purpose of this Transportation Provider Manual is to give Transportation Providers an overview of Alivi's Transportation Provider Program as well as important guidelines and processes.

This Manual will provide information on:

- Alivi's Transportation Provider program
- Alivi's responsibilities and organization
- Transportation Providers' responsibilities
- Driver, attendant and vehicle requirements
- Transportation scheduling procedures
- Transportation scheduling requirements
- Transportation performance standards
- Transportation delivery procedures

Section 1 - General Description of the Transportation Program

Non-Emergency Medical Transportation (NEMT) is a Medicaid benefit available to members that have no other means of transportation available. Other healthcare organizations offer their members NEMT services as an added value. NEMT services are important to nursing facility residents, the frail and elderly, members with disabilities and any members who need critical services such as dialysis, rehabilitation, physical therapy, or chemotherapy, and have no other means of transportation.

1.1 - Levels of Service for Transportation

Alivi contracts with Transportation Providers to provide non-emergency transportation to members who require various levels of service which include:

- Ambulatory
- Wheelchair
- Stretcher
- Basic Life Support (BLS)
- Advanced Life Support (ALS)

Transportation providers may refer to the Transportation Provider Agreement for more information about the levels of service.

Section 2 - Alivi Responsibilities

Alivi will confirm that eligible Members receive NEMT services that are safe, reliable and on time. This section sets forth the nature and scope of the brokerage services required. As the NEMT broker, Alivi coordinates all aspects of the program, including reservations, transportation provider contracting, complaint management, quality assurance, and claims payment for the full range of transportation services.

Alivi is responsible for the performance of the following tasks:

1. Recruit and maintain an adequate NEMT Provider Network.
2. Operate a call center for trip requests.
3. Verify member program eligibility in accordance with partner policy.
4. Verify that the purpose of the trip is to receive a service covered by the program.
5. Assign trips on a per-trip or recurring basis with the most appropriate, qualified and cost-effective Provider.
6. Ensure compliance with driver and vehicle requirements.
7. Adhere to the prompt pay regulations and reimburse Transportation Providers for services.
8. Develop and implement a system that tracks complaints, and complaint resolutions.
9. Develop and implement a monitoring system and quality assurance plans.
10. Provide administrative oversight.
11. Submit management reports, conduct annual member, facility, service provider, and NEMT provider satisfaction surveys, and submit an annual transportation report and ad hoc reports.
12. Submit claims/encounter files as scheduled.
13. Protect member confidentiality under HIPAA.
14. Maintain adequate staff and facilities.
15. Participate in member appeals as requested.

2.1 - Corporate & Call Center Offices

The Corporate & Call Center Offices are staffed with Alivi personnel that can respond to Provider calls and give immediate assistance with trip assignments, reports, performance reviews and help to resolve some billing issues. The Corporate & Call Center Offices assign and dispatch trip reservations and handle calls in both English and Spanish.

Headquarters: 3511 NW 91st Ave.
Doral, Florida 33172
Phone: (786) 441-8550
Reservations: (888) 998-4640
Dispatch: (786) 496-9530
Provider Relations: (786) 471-5767
Fax: (305) 402-0980

2.2 - Gatekeeping by Alivi

The gatekeeping function ensures that NEMT services are authorized and provided according to the terms and limitations of Alivi's obligations under its contract with healthcare programs including Medicare, Medicaid MCOs and as required under Medicaid and Title XXI Program regulations. NEMT services are intended only for eligible members who have no other means of transportation to covered medical services. The proprietary software systems and algorithms employed by Alivi are designed to maintain the necessary data online to promote accurate eligibility determinations. The database is continuously updated as new eligibility information becomes available. In addition, Alivi may contact the medical provider to confirm the need for transportation.

2.3 - Payment to Transportation Providers

On each business day, transportation providers shall utilize the Transportation Provider Portal to update all assigned trips for the previous business day which includes pickup time, drop off time and actual miles traveled. Alivi will verify all trips submitted for payment against computer records of trips assigned and performed.

2.3.1 - Transportation Provider Payment Schedule

Alivi will pay all fees for trips with completed trip data within thirty days following the date of the trip.

2.3.2 - Payment Disputes

Providers shall submit supporting documentation in the event of a dispute with respect to amounts owed to the Provider. Should a discrepancy continue to exist after Alivi reviews the documentation to verify charges, Alivi will pay the uncontested portion and work with the Provider to reconcile any differences.

As a condition of Payment, Provider must complete trips via the Transportation Provider Portal within 10 days of the date of service. All trips not completed within 10 days of service will be systematically cancelled. Provider has up to 30 days of date of service to submit a dispute to reverse the cancellation. Disputes submitted more than 60 days after date of service will be disallowed in their entirety.

Provider shall continue to perform its obligations hereunder irrespective of any outstanding contested amounts. Providers that make good faith efforts, as determined by Alivi in its sole discretion, to submit proper documentation within the required time frame may be allowed extensions to the trip submission time frame without penalty. Alivi agrees that it will pay or deny claims for Covered Services in accordance with the requirements of all applicable laws. Alivi shall pay provider claims for payment promptly in accordance with applicable law and in compliance with Alivi policies and procedures.

2.4 - Geographic Considerations

Alivi will schedule transportation only within the area customarily used for healthcare services by the community in which the Member resides. Alivi may schedule transportation outside the area only if appropriate medical resources are not available within the area, or a health care provider has referred the Member to covered services outside of the area, including limited out-of-state transportation services. As a general rule, Alivi will only authorize out-of-state NEMT services to and from health care providers not more than 50 miles beyond the boundaries, although other out-of-state NEMT services may be authorized on a case by case basis. All out-of-state transports require the Provider to have a US DOT number issued by the FMCSA (Federal Motor Carrier Safety Administration).

2.5 - Transportation Provider Agreements

Alivi will not establish or maintain service agreements with Providers that have been determined to have committed healthcare fraud or been terminated from a healthcare program. Alivi will terminate a service agreement with a Provider if a pattern of substandard performance is identified and the Provider fails to take satisfactory corrective action within a reasonable time period. Healthcare Programs reserve the right to direct Alivi to terminate any service agreement with a Provider when they determine it to be in the best interest of the program.

Section 3 - Transportation Provider Performance Standards

Quantifiable performance standards are an essential element of the NEMT program. Specific driver standards of customer service and conduct are incorporated into all Provider contracts. Additional proactive steps are taken, as outlined below, to maintain compliance with the spirit and intent of the performance standards.

1. Assign routes that promote the most efficient use of multi-loaded vehicles and maximize vehicle utilization.
2. Inform Members and Alivi of any service delays and use back up transportation resources to cover breakdowns.
3. Communicate with Provider Relations Representative to report any problems that may occur.
4. Provider shall establish and maintain both a telephone line and email for use by Alivi to contact Provider.
5. Provider will maintain an accurate trip log and shall furnish to Alivi upon request.
6. Provider shall require pre-employment drug screening and a pre-employment physical from all drivers.
7. Provider shall comply with all applicable city, county, state and federal laws and regulations, including all laws and regulations setting requirements regarding licensing, certification and insurance for all transportation related personnel and vehicles. If Provider operates as a “Taxi”, it shall comply with all state and local ordinances for taxis and maintain current licensing with the local taxi authority (if one exists) in each jurisdiction in which it operates. Such laws or regulations shall take priority over any conflicting provision of this Agreement and the enforcement of the conflicting provision of this Agreement is hereby waived.
8. On time performance of scheduled pickups shall be the standard practice. Arrival after the scheduled pickup time is considered a “late pickup.”
9. The driver shall make his presence known to the Member upon arrival at the pickup address and must wait at least 15 minutes after the scheduled pickup time before the Member may be considered a “no show”. If the Member is not present for pickup, the driver shall notify Provider’s dispatcher before leaving the pickup location and document the attempted pickup on the daily trip log.
10. Provider shall deliver the Member to scheduled medical appointments within 15 minutes of the medical appointment time as standard practice, however, an earlier drop off before the appointment time may be acceptable in unusual situations on a case-by-case basis. However, in no event shall a Member be dropped off for a medical appointment more than 15 minutes before the opening time of a medical office or facility. Provider shall ensure that Members are picked up at prearranged times for the return trip if the medical service provider follows a regular schedule. The prearranged times may not be changed by Provider or the driver without prior permission from Alivi.
11. If a delay occurs in the course of picking up scheduled passengers, Provider must contact waiting Members at their pickup points to inform them of the delay and the expected arrival time of the vehicle. Provider must advise scheduled passengers of alternate pickup arrangements when appropriate.
12. If a delay occurs that will result in a Member being late for a medical appointment, Provider must contact Alivi who will notify the medical provider of the late arrival or arrange alternative transportation. In the event of a vehicle breakdown, the Provider shall contact Alivi immediately to report the breakdown and to coordinate alternative transportation for Members on board.
13. No Member in a multi-load vehicle shall remain in the vehicle more than 45 minutes longer than the average travel time for direct transport from point of pickup to destination.
14. No more than 1% of Provider’s assigned trips shall be late or missed pickups. Providers with greater than 1% of their assigned trips as missed pickups may have their trips reduced. Habitual failure to meet this standard shall be a material breach of this Agreement and may result in termination of this Agreement.
15. Provider shall confirm the scheduled pickup time with the Member at least 24 hours prior to the scheduled pickup.
16. We recommend the following procedures, at a minimum, be followed:
17. Contact Members the night before the transport to confirm that they are still in need of transportation and thereby reduce the risk of a Member no show. If a Member asks or agrees with a Transportation Provider to make changes to a pickup time, this information must be submitted in advance to Alivi. Each Transportation Provider’s timely pickup compliance performance will be reported monthly.

18. Arrange pickup times to maximize the ability to appropriately multi-load while still getting the Members to their destinations on time. Reminder: The Provider must notify Alivi of any schedule time changes before performing the trip. Providers are not authorized to change pickup times without first contacting Alivi.
19. Only those trips on the Transportation Provider Portal for which Alivi has assigned a trip number are authorized for payment. Payment will not be made for trips not on the Transportation Provider Portal or not otherwise authorized by an Alivi representative.
20. Report all cancellations including passenger no shows to the call center by sending an email to notifications@alivi.com.

3.1 - Credentialing

A copy of all insurance, licensure and certification records required by the Transportation Agreement must be uploaded into the Alivi Credentialing Portal. This portal is an online tool that helps Providers electronically manage credentialing information. Once the provider submits Business, Vehicle and Driver credentialing documents, the credentialing department will be notified to review the information. Email notifications will be sent to the transportation provider to indicate the status of the credentialing. All documents must subsequently be uploaded to the portal to Alivi as they are renewed. Providers must establish, maintain and provide to Alivi within 3 days of request, or as otherwise required under the Transportation Agreement, the following records and related information.

3.1.1 - Business Credentialing

As part of the onboarding process, each Provider must submit the following business credentialing:

1. Licenses from County in which the Provider conducts business – Vehicle for Hire (If Applicable)
2. Completed W-9
3. Certificate of Insurance (General & Auto Liability) naming "EpicMD Technologies, LLC DBA Alivi NEMT Network" as additional insured on the accord. Address: 3511 NW 91 Ave, Doral, Florida 33172
    a. General Liability Requirements
        i. Each Occurrence - $300,000
        ii. Personal Injury - $300,000
        iii. General Aggregate - $600,000
    b. Auto Liability Requirements
        i. Combined Single Limit or Bodily Injury - $300,000
4. Vehicle Schedule from insurance company for those vehicles that will be used to provide service
5. Drivers Schedule from insurance company for driver who will provide service
6. Disclosure of Ownership Form
7. Alivi Direct Deposit Form (EFT)
8. Voided Check
9. Owner(s) HIPAA Training Certificate
10. Owner(s) Fraud, Waste & Abuse Training

3.1.2 - Vehicle Credentialing

As part of the onboarding process, each Provider must submit the following vehicle credentialing:

1. Current Vehicle Registration
2. Picture of vehicle
3. Current vehicle inspection report
4. Type of service each vehicle provides – ambulatory, wheelchair or stretcher

3.1.3 - Driver Credentialing

Alivi will pull a National Background Check, Motor Vehicle Record (for prior 7 years), Sex Offender Registry and Healthcare Sanctions (OIG, LEIE, etc.) on all drivers. As part of the onboarding process, each Provider must submit the following driver credentialing:

1. Current Driver's License (State of Operation)
2. County Hack License (If Applicable)
3. Drug Test (10 Substance Panel - Yearly)
4. DOT Physical (Every 2 Years)
5. First Aid Certificate (Every 2 Years)
6. CPR Certificate (Every 2 Years)
7. PAT/PASS Certificate (Every 3 Years)
8. Defensive Driver Certificate
9. Fraud, Waste & Abuse Certificate (Yearly)
10. HIPAA Certificate (Every 2 Years)

3.2 - Gatekeeping by the Transportation Provider

The Provider plays an important role in identifying gaps and errors in the information received from MCOs and members during phone reservations. Providers must inform Alivi's Logistics Coordinators if address information or scheduled pickup or appointment times are inaccurate.

Any Provider who has reason to believe that a member should not be transported should contact Alivi immediately. This notification should include member's name, ID number and date, as well as the reason the transport is inappropriate. Such reasons may include that member has access to transportation, there is a closer medical provider available, member is not being transported to a covered service, or member is assigned to the wrong level of service (assigned to wheelchair or stretcher but member is able to walk).

Providers must contact Alivi if they believe that an inappropriate level of service has been ordered for a Member. If a situation requires immediate attention, a Provider can call the Dispatch Line. Otherwise, information can be emailed to logistics@alivi.com .

3.3 - Transportation Assignment and Notification

1. Initial trip assignment lists are accessible in the Transportation Provider Portal at 2:00 PM the day prior to service.
2. Once trips have been loaded into the portal, an email is sent to the Provider with the total number of trips assigned for the next day.
3. Providers must review each trip to determine all meet the level of service they provide and the geographic area they serve.
4. Trips outside of the Provider's service capability must be sent back to Alivi's logistics email within 3 hours of receipt of the trip assignment list including the reason for rejecting the trip.
5. Providers may download their assigned trips from the Transportation Provider Portal as a Comma Separated Values (CSV) file.
6. Providers may receive additional/cancelled trips after receiving the initial trip assignment list. Any trips that are assigned to the Provider after 3:00 PM the day before the trip will be verbally confirmed with the Provider.
7. If a Provider continually receives excessive trip assignments, they should contact their Provider Relations Representative to confirm that the office's information for vehicle capacity is correct. Providers that reject reservations without a valid reason, or who do not reject reservations in a timely fashion, may have trip volume reduced or placed on a Corrective Action Plan.

3.3.1 - Will Calls

Return trips for Members are authorized during the reservation process. However, members often do not know an exact return time, therefore, it will appear as "Will Call" on the Transportation Provider Portal. When the member calls the call center for a return ride, the CSR contacts the Provider to advise the member is ready for a return pickup. The Provider shall accept the return ride and provide the appropriate pickup time, which in no event shall exceed:

- 30 minutes – curb-to-curb
- 45 minutes – door-to-door
- 60 minutes – wheelchair / stretcher

Alivi is required to arrange transportation for hospital discharges within a 3-hour window from the time that the call is received. Standard on-time pickup requirements will be adhered to for scheduled urgent pickups.

3.3.2 - Escorts

An Escort or personal assistant may ride with a Member at no extra charge. The Escort or personal assistant is expected to assist the Member and the driver as requested. Up to two children may ride with an eligible Member, on a space available basis, also at no charge. The parent or guardian must provide appropriate car seats for infants and children. A parent or guardian must accompany any children below the age of eighteen (18) unless a signed waiver is on file with Alivi, enabling children seventeen (17) and under to be transported without parent or guardian. Escorts, personal assistants and children must be included on the original trip reservation to ensure adequate space on the vehicle.

Provider must allow certified service animals in the vehicle, as needed; however, other animals shall not be allowed on board the vehicle.

3.4 - Vehicle Requirements

All vehicles utilized under the NEMT program must be registered with and inspected by Alivi on an annual basis. Alivi's Quality Assurance Specialists will utilize a standard checklist. Vehicles that pass inspection will be issued an inspection sticker which must be placed on the outside of the passenger side, rear window in the lower right corner. A sample of the Vehicle Inspection Form is attached to this manual.

Any vehicle found non-compliant with Alivi's inspection standards, licensing requirements, safety standards, Highway and Transportation Department, or ADA regulations, or other State or Federal laws or regulations shall be immediately suspended from service and shall pass a re-inspection before it may be used to provide transportation services for Members. Trips performed using non-compliant vehicles will not be paid.

1. Vehicles shall comply with the Americans with Disabilities Act (ADA) Accessibility Specifications for Transportation as well as Federal Transit Administration (FTA) regulations, as applicable for the type of vehicle utilized by Provider.
2. The number of occupants in the vehicle, including the driver, shall not exceed the vehicle manufacturer's approved seating capacity.
3. All vehicles shall have functioning seat belts and restraints as required by applicable law. All vehicles shall have an easily visible interior sign that states: "ALL PASSENGERS SHALL USE SEAT BELTS". Seat belts must be stored off the floor when not in use.
4. Provider shall have at least two seat belt extensions available in each vehicle.
5. All vehicles shall be equipped with at least one seat belt cutter and glass break tool that is kept within easy reach of the driver for use in emergency situations.
6. All vehicles and component must meet or exceed, and be maintained and operated in accordance with, the manufacturer's, state, federal and local safety and mechanical operating and maintenance standards.
7. All vehicles shall have permanent signage that displays Provider's business name and telephone number on both exterior sides of the vehicle. The business name and phone number must appear in permanently affixed lettering that is a minimum of three inches in height and of a color that contrasts with its surrounding background.
8. The vehicle license number and Alivi's toll-free and local phone numbers (voice and TTY) shall be prominently displayed in the interior of each vehicle. This information, together with complaint procedures provided by Alivi shall be available in writing and stored in a clearly visible location in each vehicle for distribution to Members upon request.
9. Smoking shall be prohibited in all vehicles at all times. All vehicles shall have an easily visible interior sign that states: "NO SMOKING".
10. All vehicles shall carry a vehicle information packet containing vehicle registration, insurance card, and accident procedures and forms.
11. All vehicles shall be equipped with a first aid kit stocked with at least the following items: antiseptic cleansing wipes, triple antibiotic ointment, assorted sizes of adhesive and gauze bandages, dressing pads, cold pack, oval eye pad, triangular bandage, insect sting relief pads or cotton applicators, tape, scissors, latex or other impermeable gloves and sterile eyewash.
12. All vehicles shall be equipped with portable triangular reflectors mounted on stands. Use of flares is prohibited and may not be carried on board.
13. All vehicles shall carry a functioning flashlight.
14. All vehicles shall be equipped with a "spill kit" that includes liquid spill absorbent, latex or other impermeable gloves, hazardous waste disposal bags, scrub brush, disinfectant and deodorizer.
15. All vehicles shall be equipped with a working fire extinguisher (Class A, B, or C) that shall be securely fastened and stored in a safe location within easy reach of the driver.
16. Provider shall utilize only its own leased or owned vehicles and shall not sublet, subcontract or arrange for transportation under this Agreement from any third party.
17. All vehicles must be equipped with a two-way communications system linking each vehicle with the Provider's primary place of business.

18. All vehicles must properly utilize approved child safety seats when transporting children in accordance with State laws and regulations. Members are responsible for providing child safety seats when transporting children under the age of 8 years old. Upon arrival for transportation, if the Member does not provide safety seat(s) for any child under age 8, the Member shall not transport the child and shall advise the Member to reschedule the appointment.
19. All vehicles shall be equipped with a retractable step, fixed sideboard (running board), or a step stool approved by Alivi to aid Passenger boarding. This step shall be capable of safely supporting 300 pounds and shall be no more than 12 inches above ground level. The step shall have a nonskid top surface no less than eight inches by twelve inches. Removable steps shall be properly secured while the vehicle is in motion. Under no circumstances will a milk crate or similar substitute be accepted as a substitute for a step stool.

3.4.1 - Wheelchair Vehicle Requirements

All vehicles used to transport wheelchair passengers ("Wheelchair Vehicle") must meet the Vehicle Requirements set forth above as well as the following additional requirements:

1. Each Wheelchair Vehicle must maintain a floor-to-ceiling height clearance in the passenger compartment of at least 56 inches.
2. Each Wheelchair Vehicle must have an engine-wheelchair lift interlock system that requires the Wheelchair Vehicle's transmission to be in park and the emergency brake engaged to prevent vehicle movement when the lift is deployed.
3. All wheelchair ramps or lifts used on vehicles shall be certified as capable of regularly servicing a 600 pound load.
4. Each Wheelchair Vehicle with a hydraulic or electromechanical powered wheelchair lift must have the lift mounted so not to impair the structural integrity of the vehicle. Lift capacities for all wheelchair vehicles must be reported to Alivi. The lift must meet the following specifications:
    a. Capable of elevating and lowering a 600 pound load without the outer edge of the lift sagging or tilting downwards more than 1 inch, nor shall the platform deflection be more than 3 degrees under a 600 pound load.
    b. Must be at least 30 inches wide and 48 inches long.
    c. Shall not have a gap between the platform surface and the roll-off barrier greater than 5/8 of an inch. When raised, the gap between the platform and the vehicle floor shall not exceed 1/2 inch horizontally and 5/8 inch vertically.
    d. Controls shall be accessible and operable from inside or outside the vehicle and shall be secure from accidental or unauthorized operation.
    e. Shall be powered from the vehicle's electrical system. The lift platform shall be able to be raised/lowered manually with passengers and/or shall provide a method to slow free-fall in the event of a power failure or component failure.
    f. Operation shall be smooth without jerking motion. Movement shall be less than or equal to 6 inches per second during lift cycle and less than or equal to 12 inches per second during stowage cycle.
    g. Platform shall not be capable of falling out of or into the vehicle when in storage in the passenger compartment, even if the power should fail.
    h. All sharp edges of the lift structure which might be hazardous to passengers shall be padded or ground smooth.
    i. Platform shall have a properly functioning, automatically engaged, anti-roll-off barrier, with a minimum of 1 inch on the outbound end to prevent ride over.
    j. It is preferable that the platform, when stored, not intrude into the body of the vehicle more than 12 inches and shall be equipped with permanent vertical side plates to a height of at least 2 inches above the platform surface.
    k. Platform surface shall be equipped with non-skid expanded metal mesh or equivalent, to allow for vision through the platform.
    l. The lift platform must be equipped with a hand rail on both sides of the platform to assist loading or unloading ambulatory passengers. The handrail shall meet the following requirements:
        i. Maximum height of 38 inches.
        ii. Minimum knuckle clearance of 1.5 inch.

iii. Able to withstand a force of 100 pounds.
iv. Shall not reduce the lift platform width of at least 30 inches.
v. Each wheelchair position in all vehicles shall have a wheelchair securement device (or "tie down") which shall:
    1. Be placed as near to the accessible entrance as practical, providing clear floor area of 30 inches by 48 inches. Up to 6 inches may be under another seat if there is 9 inches height clearance from floor. All wheelchairs shall be forward facing.
    2. Be tested to meet a 30 mph/20 gm standard.
    3. Securely restrain the wheelchair during transport from moving forward, backward, lateral and tilting movements more than 2 inches.
    4. Be adjustable to accommodate all wheel bases, tires (including pneumatic), and motorized wheelchairs.
    5. Have a lock system, belt system, or both. If a belt system is used, the cargo strap when not in use shall be retractable or stored on a mounted clasp or in a storage box. A tract mounting lock system on the floor shall be flush with the floor and shall not be an obstruction or a tripping hazard. In all cases the straps shall be stored properly when not in use.
    6. Provide seat belts and/or shoulder harness that are attached to the floor or to the side wall of the vehicle, that shall be capable of securing both the passenger and wheelchair.

5. Each wheelchair entrance door shall:
    a. Maintain a minimum vertical clearance of 56 inches and a minimum clear door opening of 30 inches wide.
    b. Have no lip or protrusion at the door threshold of more than 1/2 inch.
    c. Be equipped with straps or locking devices to hold the door open when the lift or ramp is in use.
6. Wheelchair vehicles assigned to hospital discharges and/or trip requests that require a wheelchair to be provided, shall secure and carry on board one spare wheelchair in good condition with a minimum seat width of 20 inches.

3.4.2 - Stretcher Vehicle Requirements

Stretcher van service is an alternative mode of non-emergency medical transportation. It shall be provided to an individual who cannot be transported in a sedan or wheelchair van and who does not need the medical services of an ambulance. All stretcher vehicles must meet the General Vehicle Requirements set forth above as well as the following additional requirements.

1. A driver and an attendant shall staff the vehicle, which shall be specifically designed and equipped to provide non-emergency medical transportation of individuals on an approved stretcher. A stretcher vehicle shall be used for an individual who:
    a. Needs routine transportation to or from a non-emergency medical appointment or service.
    b. Is convalescent or otherwise non-ambulatory and cannot use a wheelchair.
    c. Does not require medical monitoring, medical aid, medical care or medical treatment during transport. Self-administered oxygen is permitted as long as the oxygen tank is secured safely.

2. The following restrictions apply:
    a. A stretcher passenger shall not be left unattended at any time.
    b. The driver and attendant shall confirm that all restraining straps are fastened properly and that the stretcher, stretcher fasteners and anchorages are properly secured.
    c. The attendant shall be seated in the passenger compartment while the vehicle is in motion and shall notify the driver of any sudden change in the passenger's condition.
    d. The stretcher vehicle shall not be used:
        i. for emergency medical transportation;
        ii. to transport a passenger who requires basic or advanced life support;

iii. to transport a passenger who has in place any temporary invasive device (including a saline lock), equipment such as an intravenous administration device, or an airway maintenance device. However, the Member is eligible for transportation if he/she has a battery-operated ventilator and an adult escort trained to provide ventilator care, will travel with the Member, and if no other medical equipment or care is required.
iv. to transport a passenger who requires close observation or medical monitoring;
v. to transport more than 1 stretcher passenger at a time.

3.4.3 - Non-Emergency Ambulance Vehicle Requirements

All vehicles used to transport Members that require covered non-emergency BLS or ALS service must meet the General Vehicle Requirements set forth above as well as the following additional requirements. State or local laws or regulations establishing minimum operational standards for Ambulances shall supersede the following provisions:

1. Ambulance vehicle must have at least 1 gurney that is capable of supporting 400 pounds or more.
2. Each gurney must have the capability to be lowered and raised from a height of 18 inch to a height necessary to load the gurney into the vehicle without requiring the gurney to be manually lifted from the ground.
3. Each gurney must be equipped with no less than one safety belt.
4. Ambulance vehicle must have the necessary equipment to “lock” the gurney securely in place while in the vehicle.

3.5 - Driver Requirements and Service Standards

All drivers and attendants used to perform services under the Transportation Provider Agreement shall, at a minimum, meet the applicable qualifications listed below before performing services under this agreement. Each driver’s and attendant’s records and qualifications are subject to an initial and annual inspection by Alivi as well as interim inspections as required by Alivi in its sole discretion. Any driver or attendant failing, at any time, to meet all of the applicable qualifications, or any requirements imposed by state or local law, shall be prohibited from providing service under this Agreement. Alivi and the Client reserve the right to disallow any driver or attendant from performing services under this Agreement. Any trips performed by non-compliant drivers will not be paid.

1. No driver or attendant shall use alcohol, narcotics, illegal drugs or drugs that impair his or her ability to perform while on duty or abuse alcohol or drugs at any time. A driver or attendant can use prescribed medication as long as his/her duties can still be performed in a safe manner and Provider has written documentation from a physician or pharmacist that the medication will not impact the ability of the driver.
2. Driver must speak English fluently.
3. No drivers or attendants shall allow firearms, alcoholic beverages in opened containers, unauthorized controlled substances, or highly combustible materials to be transported in the vehicle.
4. No drivers or attendants shall solicit or accept controlled substances, alcohol or medications from Members.
5. No drivers or attendants shall make sexually explicit comments, or solicit sexual favors, or engage in sexual activity while in the course of their job duties.
6. No drivers or attendants shall solicit additional business or accept money or goods from Members except for the collection of applicable co-payments as authorized by the Client.
7. Drivers and attendants shall not touch any Passengers except as appropriate and necessary to assist the Member into or out of the vehicle, into a seat, to secure the seat belt, or to render first aid or assistance for which the driver or attendant has been trained.
8. All drivers and attendants shall wear and have visible a nametag that is easily readable and includes their name and the name of the Provider.
9. No drivers or attendants shall smoke while in the vehicle, while assisting Passengers, or in the presence of any Passengers. Members shall not be allowed to smoke in the vehicle.

10. No drivers or attendants shall wear any type of headphones while on duty, with the exception of hands- free headsets for mobile telephones. Mobile telephones, including texting, may not be used while the vehicle in is motion.
11. All drivers shall park the vehicle so that the Passenger does not have to cross streets to reach the entrance of the destination.
12. No drivers or attendant shall leave a Passenger unattended at any time and the vehicle should remain visible to the driver when performing door-to-door services.
13. All drivers and/or attendants must identify themselves (show their name tag) to the member, facility representative, or other service provider employee, and announce their presence at the entrance of the building at the specified pickup location if a curbside pickup location is not apparent.
14. The driver or attendants must open and close the vehicle door when Passengers enter or exit the vehicle and assist the Passengers in the process of being seated, including the fastening of seat belts. Drivers shall confirm prior to moving the vehicle that wheelchairs and wheelchair passengers are properly secured and that all Passengers are properly belted in their seat belts.
15. All drivers and/or attendants must assist Passengers to exit the vehicle and to move to the access area of the Member's destination. All drivers shall confirm that the delivered passenger is safely inside his or her destination prior to vehicle departure.
16. All drivers and/or attendants must provide physical support or assistance and oral directions to Passenger when requested or when necessitated by the passenger's mobility status and personal condition. Such assistance can include curb-to-curb, and door-to-door assistance as indicated on the trip manifest and may also apply to wheelchairs and mobility-limited persons as they enter or exit the vehicle using a wheelchair lift or ramp. Such assistance shall also include stowage of mobility aids such as canes, walkers and folding wheelchairs.
17. All drivers and/or attendants shall assure that any packages are safely stored before the driver moves the vehicle. Drivers and/or attendants are not responsible for Passenger's personal items.
18. All drivers and attendants shall be courteous, patient and helpful to all Members and be neat and clean in appearance.
19. If a Passenger's behavior or any other condition impedes the safe operation of the vehicle, the driver shall park the vehicle in a safe location out of traffic, notify the Provider, and request assistance.
20. Drivers and attendants shall comply with HIPAA and keep all Member's health care identifying information confidential and not visible to other passengers and shall not discuss health care identifying information with anyone who is not involved with the Member's treatment or other health care services.
21. Any driver or attendant who receives two substantiated complaints in a 90 day period must be removed from driving under this Agreement or enter a retraining program. If a driver receives four substantiated complaints within a 12 month time period, he/she must be permanently removed from driving under this Agreement.
22. All drivers shall maintain a daily trip log that includes the following information:
    a. Provider name;
    b. Provider ID number
    c. Vehicle number;
    d. Driver's name (as it appears on driver's license, no nicknames);
    e. Driver's signature
    f. Departure time from and return time to base station
    g. Names of Members and all other passengers transported
    h. Member's signature for each drop off
    i. No show indicator, if applicable;
    j. Actual arrival time at pickup point;
    k. Actual arrival time at drop-off point;
    l. Date of service and mode of transport authorized;
    m. Name of attendant (if any) and attendant's signature;
    n. Authorization stamp or signature of Provider, and
    o. Any other pertinent information regarding completion of trips.

Section 4 - Noncompliance & Member Safety

4.1 - Complaint Process

Complaints include those received from Members, medical providers or facilities, Providers or any other individual or entity that contacts Alivi.

Transportation Providers are required cooperate with Alivi when they are contacted to provide response to a Health Plan or related partner regarding a grievance that needs resolution. The Transportation Provider must respond within the specified timeframe.

Complaints are recorded within the system and are investigated by Alivi personnel. Complaints are tracked based on their nature as well as any identified Provider involved. Excessive complaints concerning a specific Provider may result in a corrective action plan which can include a decrease in work assigned to the Provider, or a removal from the NEMT network.

Members or medical providers may file complaints about late trips by calling the Call Center. The Call Center will attempt to resolve matters concerning immediate transportation needs and complaints will be assigned to a Quality Assurance Coordinator. Providers may register general complaints by calling their assigned Provider Relations Representative.

4.2 - Corrective Action Plan (CAP)

Non-Compliant Providers will have the following action taken:

Step 1: Email and phone call stating the Provider is non-compliant, describing the reason why they are non-compliant and providing the CAP.

Step 2: If the Provider continues to be non-compliant, a Transportation Provider Agreement suspension notice or letter in lieu of suspension will be mailed to the Provider.

Step 3: If the Provider continues to be non-compliant after initial notice and suspension notice, a letter of Termination will be sent to the Transportation Provider.

4.2.1 - Infractions Leading to Non-Compliance

1. Multiple Tardiness
2. Multiple No Shows
3. Inappropriate Driver Behavior
4. Expired Credentials
    a. Company
    b. Vehicle
    c. Driver
5. Transportation Provider providing false or misleading documents
6. Multiple Rejected Trips

4.3 - Proper Wheelchair Securement

Drivers who fail to properly secure wheelchair clients will be immediately suspended from operating under this contract.

First Occurrence: Driver will be required to attend training. Driver will be reinstated upon successful completion of the class.

Second Occurrence: Driver will be permanently suspended from operating under NEMT program.

4.4 - Incident Reporting & Procedures

The Provider must promptly notify Alivi of any accident or incident resulting in driver or passenger injury or fatality. An Alivi Transportation Provider Accident/Incident Report Form shall be submitted to Alivi within 24 hours, and follow up documentation, such as police report shall be submitted within three (3) business days or as soon the documents are available from the police. Should an accident occur, regardless of fault, the Transportation Provider must send the responsible driver for post-accident drug and alcohol testing at their expense and submit the results to Alivi.

A sample Transportation Provider Accident and Incident Report must be used to report all accidents or incidents, which occur while delivering NEMT services. A sample of the report in the back of this manual and additional copies can be obtained from your assigned Provider Relations Representative.

The Provider will cooperate with Alivi during any ensuing investigation. This form must be included in the vehicle information packet stored in the driver compartment or securely stored on or in the driver's side visor.

Provider shall report to Alivi any suspected abuse, neglect or exploitation of children or incapacitated adults, or of any adult over the age of 60.

Section 5 - Fraud, Waste and Abuse Policy

Federal law requires that entities such as Alivi and its subsidiaries receive at least $5 million in annual payments under a State Medicaid program, establish written policies for its employees, contractors and agents that furnish detailed information regarding the federal and state False Claims Acts, the administrative remedies available under the acts, other protection under the acts, and the Company's procedures for detecting fraud, waste and abuse.

Alivi's policy is to provide detailed information to all employees, contractors and agents about federal and state False Claims Acts and the Company's policies and procedures to detect and prevent fraud, waste and abuse. The information in this policy forms part of its employee manual, its transportation provider manual, and is distributed to all contractors and agents as required by the Deficit Reduction Act of 2005.

5.1 - Federal False Claims Act

The federal False Claims Act, among other things, applies to the submission of claims by healthcare providers for payment by Medicare, Medicaid and other federal and state healthcare programs. The False Claims Act is the federal government's primary civil remedy for improper or fraudulent claims. It applies to all federal programs, from military procurement contracts to welfare benefits to healthcare benefits.

The False Claims Act prohibits, among other things:

- Knowingly presenting or causing to be presented to the federal government a false or fraudulent claim for payment or approval.
- Knowingly making or using, or causing to be made or used, a false record or statement in order to have a false or fraudulent claim paid or approved by the government.
- Conspiring to defraud the government by getting a false or fraudulent claim allowed or paid.
- Knowingly making or using, or causing to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the government.
- "Knowingly" means that a person, with respect to information: 1) has actual knowledge of the information; 2) acts in deliberate ignorance of the truth or falsity of the information; or 3) acts in reckless disregard of the truth or falsity of the information.

5.2 - Enforcement

The United States Attorney General may bring civil actions for violations of the False Claims Act. As with most other civil actions, the government must establish its case by presenting a preponderance of the evidence rather than meeting the higher burden of proof that applies in criminal cases. The False Claims Act allows private individuals to bring "qui tam" actions for violations of the False Claims Act.

5.3 - Employee Protection

If any employee has knowledge or information that any such activity may have taken place, the employee should notify his or her supervisor or other management official. Providers must have a system in place for reporting potential violations, and such information may be reported anonymously. Federal and state law as well as Alivi policy prohibit any retaliation or retribution against any person who reports suspected violations of these laws to law enforcement officials or who file lawsuits on behalf of the government. Anyone who believes that he or she has been the subject to any such retaliation or retribution should also report this to their supervisor or other appropriate person, as provider by their employer's policy covering such matters.

5.4 - Program Fraud Civil Remedies Act of 1986

The Program Fraud Civil Remedies Act of 1986 ("PFCRA") authorizes federal agencies such as the Department of Health and Human Services to investigate and assess penalties for the submission of false claims to the agency. The conduct prohibited by the PFCRA is similar to that prohibited by the False Claims Act. For example, a person may be liable under the PFCRA for making, presenting, or submitting, or causing to be made, presented, or submitted, a claim that the person knows or has reason to know:

- is false, fictitious, or fraudulent;
- includes or is supported by any written statement that:
- omits a material fact;
- is false, fictitious, or fraudulent as a result of such omission; and
- include such material fact; or
- is for payment for the provision of property or services which the person has not provided as claimed.

If a government agency suspects that a false claim has been submitted, it can appoint an investigating official to review the matter. The investigating official may issue a subpoena to further investigate or may refer the matter to the Department of Justice for proceedings under the False Claims Act. If, based on the investigating official's report, an agency concludes that further action is warranted, it may issue a complaint regarding the false claim. A hearing following the detailed due process procedures set forth in the regulations implementing the PFCRA would be held.

5.5 - State False Claims Acts

Several states have enacted False Claims Acts that are similar in substance and procedure to the Federal laws described, above. At present, these States include AR, CA, DE, DC, FL, GA, HI, IN, IL, LA, MA, MI, MN, MO, MT, NH, NJ, NM, NY, NV, OK, RI, TN, TX, VA, and WI. In addition, the municipalities of Chicago and New York City have enacted False Claims Acts that are similar in substance and procedure to the Federal laws described above.

5.6 - Fraud, Waste and Abuse / Company Detection

Alivi has numerous policies and procedures for detecting fraud, waste and abuse. Some of our more important procedures are (1) the gate keeping protocol performed during the reservation process; (2) the detailed verification process for each invoice submitted by transportation providers; (3) recertification of standing orders, (4) sampling patient attendance records with health care facilities; (5) background check requirement for transportation providers; (6) field monitor activities; and (7) requirement of preauthorization and job number. Alivi takes seriously any allegation of fraud, waste or abuse, and appropriately investigates any such allegation. Providers are required to report suspected cases of fraud, waste, abuse or other impropriety. Providers must cooperate in any investigations initiated by Alivi or any government agency, as required by law.

Section 6 - Medicare Advantage Program Requirements

To the extent that any Alivi Client offers NEMT services to Medicare beneficiaries, the Centers for Medicare and Medicaid Services ("CMS") and associated laws, rules and regulations regarding the Medicare Advantage ("MA") Program require that the Client provide for compliance of contracted network providers and their respective employees with certain MA program requirements including, without limitation, inclusion of certain mandatory provisions in MA provider participation agreements and/or associated documents including agreements between Alivi and subcontracted transportation providers, as applicable. A list of some of these requirements can be found in the CMS Managed Care Manual, Chapter 11, Section 100.4, as published by CMS and available on the CMS website. Additionally, revisions to certain applicable regulations can be found in 74 Fed. Reg. 1494 (January 12, 2009) (amending 42 C.F.R. Parts 422 and 423). As such and in addition to the terms and conditions in the Agreement between Alivi and Provider, Provider agrees to the following terms and conditions to the extent applicable to NEMT services rendered to Medicare beneficiaries enrolled in MA health benefit plans. Provider will maintain full participation status in the federal Medicare program and shall ensure that any employee, contractor and/or subcontractor of Provider is not excluded from providing services to Medicare beneficiaries under the Medicare program. In the event of a conflict between the contract between Alivi and Provider related to services rendered to Medicare beneficiaries and applicable provisions of this Medicare Advantage Program Provider Requirements Addendum ("Addendum"), this Addendum shall control.

II. Definitions. For purposes of this Addendum the following additional terms shall have the meaning set out below:

(1) "Covered Services" means those Medically Necessary medical, related health care and other services covered under and defined in accordance with the applicable Medicare beneficiary's MA Plan.

(a) Covered Services means the benefits covered under the applicable Medicare Advantage PLAN and for which Alivi and/or PLAN has the obligation to pay, as described and set forth in the applicable Evidence of Coverage, including any endorsements and passengers thereto.

(b) Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

(i) serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;

(ii) serious impairment to bodily functions; or

(iii) serious dysfunction of any bodily organ or part.

(c) Emergency Services means Covered Services which are either inpatient or outpatient services that are:

(i) furnished by a provider qualified to furnish emergency services; and

(ii) needed to evaluate or stabilize an Emergency Medical Condition.

(2) "Dual Eligible Member" means a Medicare beneficiary who is also entitled to medical assistance under a state plan under Title XIX ("Medicaid") of the Social Security Act (the "Act").

(3) "First Tier Entity" means Alivi.

(4) "Health Plan" means the entity that offers the MA health benefit plans with which Medicare beneficiaries participate.

(5) "MA Plan" means the one or more MA health benefit plans offered or administered by Health Plan(s) for Medicare beneficiaries and under which Provider renders services to Medicare beneficiaries.

(6) "Medicare Advantage Program or MA Program" means the federal Medicare managed care program for Medicare Advantage (formerly known as Medicare+Choice) products run and administered by CMS, or CMS' successor.

(7) "Medicare Contract" means Health Plan's contract(s) with CMS to arrange for the provision of health care services to certain persons enrolled in an MA Plan who are eligible for Medicare under Title XVIII of the Social Security Act.

(8) "State" means the state in which Provider provides the Covered Services.

(9) "State Medicaid Plan" the State's plan for medical assistance developed in accordance with Section 1902 of the Act and approved by CMS.

(10) "Medicare beneficiary" means those designated individuals eligible for traditional Medicare under Title XVIII of the Social Security Act and CMS rules and regulations and enrolled with Health Plan.

III. Additional MA Program Obligations and Requirements. Provider agrees to the following terms and conditions to the extent applicable to NET services rendered to Medicare beneficiaries.

A. Audits; Access to and Record Retention. Provider shall permit audit, evaluation and inspection directly by Health Plan, the Department of Health and Human Services (HHS), the Comptroller General, the Office of the Inspector General, the General Accounting Office, CMS and/or their designees, and as the Secretary of the HHS may deem necessary to enforce the Medicare Contract, physical facilities and equipment and any pertinent information including books, contracts (including any agreements between Provider and its employees, contractors and/or subcontractors providing services related to services provided to Medicare beneficiaries), documents, papers, medical records, patient care documentation and other records and information involving or relating to the provision of services under the Agreement, and any additional relevant information that CMS may require (collectively, "Books and Records"). All Books and Records shall be maintained in an accurate and timely manner and shall be made available for such inspection, evaluation or audit for a time period of not less than ten (10) years, or such longer period of time as may be required by law, from the end of the calendar year in which expiration or termination of the agreement under which Provider renders services to Medicare beneficiaries occurs or from completion of any audit or investigation, whichever is greater, unless CMS, an authorized federal agency, or such agency's designee, determines there is a special need to retain records for a longer period of time, which may include but not be limited to: (i) up to an additional six (6) years from the date of final resolution of a dispute, allegation of fraud or similar fault; (ii) completion of any audit should that date be later than the time frame(s) indicated above; (iii) if CMS determines that there is a reasonable possibility of fraud or similar fault, in which case CMS may inspect, evaluate, and audit Books and Records at any time; or (iv) such greater period of time as provided for by law. Provider shall cooperate and assist with and provide such Books and Records to Health Plan and/or CMS or its designee for purposes of the above inspections, evaluations, and/or audits, as requested by CMS or its designee and shall also ensure accuracy and timely access for Medicare beneficiaries to their medical, health and enrollment information and records. Provider agrees and shall require its employees, contractors and/or subcontractors and those individuals or entities performing administrative services for or on behalf of Provider and/or any of the above referenced individuals or entities: (i) to provide Health Plan and/or CMS with timely access to records, information and data necessary for: (1) Health Plan to meet its obligations under its Medicare Contract(s); and/or (2) CMS to administer and evaluate the MA program; and (ii) to submit all reports and clinical information required by Health Plan under the Medicare Contract. [42 C.F.R. §§ 422.504(e)(4), 422.504 (h), 422.504(i)(2)(i), 422.504(i)(2)(ii) and 422.504(i)(4)(v)]

B. Privacy and Accuracy of Records. In accordance with the CMS Managed Care Manual and the regulations cited below, Provider agrees to comply with all state and federal laws, rules and regulations, Medicare program requirements, and/or Medicare Contract requirements regarding privacy, security, confidentiality, accuracy and/or disclosure of

records (including, but not limited to, medical records), personally identifiable information and/or protected health information and enrollment information including, without limitation: (i) HIPAA and the rules and regulations promulgated thereunder; (ii) 42 C.F.R. § 422.504(a)(13); and (iii) 42 C.F.R. § 422.118; (d) 42 C.F.R. § 422.516 and 42 C.F.R. § 422.310 regarding certain reporting obligations to CMS. Provider also agrees to release such information only in accordance with applicable state and/or federal law, including pursuant to valid court orders or subpoenas.

C. Hold Harmless of Medicare Beneficiaries. Provider hereby agrees: (i) that in no event including, but not limited to, non-payment by Health Plan or First Tier Entity, Health Plan's determination that services were not Medically Necessary, Health Plan's or First Tier Entity's insolvency, or breach of the agreement between Provider and First Tier Entity that is the subject hereof or the agreement between First Tier Entity and Health Plan, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Medicare beneficiary for amounts that are the legal obligation of Health Plan and/or First Tier Entity; and (ii) that Medicare beneficiaries shall be held harmless from and shall not be liable for payment of any such amounts. Provider further agrees that this provision (a) shall be construed for the benefit of Medicare beneficiaries; (b) shall survive the termination of the agreements between Provider and First Tier Entity and First Tier Entity and Health Plan regardless of the cause giving rise to such termination; and (c) supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and Medicare beneficiaries, or persons acting on behalf of a Medicare beneficiary. [42 C.F.R. § 422.504(g)(1)(i) and (i)(3)(i)]

D. Hold Harmless of Dual Eligible Members. With respect to those Medicare beneficiaries who are designated as Dual Eligible Members for whom the State Medicaid agency is otherwise required by law, and/or voluntarily has assumed responsibility in the State Medicaid Plan to cover those Medicare Part A and B Member Expenses identified and at the amounts provided for in the State Medicaid Plan, Provider acknowledges and agrees that it shall not bill CMS, Medicare or Medicare beneficiaries the balance of ("balance-bill"), and that such Medicare beneficiaries are not liable for, such Medicare Part A and B Member Expenses, regardless of whether the amount Provider receives is less than the allowed Medicare amount or Provider charges due to limitations on additional reimbursement provided in the State Medicaid Plan. Provider agrees that it will accept First Tier Entity's payment as payment in full or will bill the appropriate State source if Health Plan has not assumed the State's financial responsibility under an agreement between Health Plan and the State. [42 C.F.R. § 422.504(g)(1)(iii).]

E. Accordance with Health Plan's Contractual Obligations. Provider agrees that any services provided to Medicare beneficiaries shall be consistent with and comply with the requirements of the Medicare Contract. [42 C.F.R. § 422.504(i)(3)(iii).]

F. Prompt Payment of Claims. First Tier Entity will process and pay or deny claims for Covered Services within the timeframe set forth in the agreement between Provider and First Tier Entity. [42 C.F.R. § 422.520(b).]

G. Delegation of Provider Selection. As applicable, Provider understands that if selection of providers who render services to Medicare beneficiaries has been delegated to First Tier Entity by Health Plan, either expressly or impliedly, then Health Plan retains the right to approve, suspend or terminate such downstream or subcontracted arrangements to the extent applicable to Medicare beneficiaries enrolled with Health Plan. [42 C.F.R.§ 422.504(i)(5).]

H. Compliance with Health Plan's Policies and Procedures. Provider shall comply with all policies and procedures of Health Plan to the extent applicable to the services rendered by Provider. Such policies may include written standards for the following: (a) timeliness of access to care and member services; (b) policies and procedures that allow for individual medical necessity determinations (e.g., coverage rules, practice guidelines, payment policies); and (c) Health Plan's compliance program which encourages effective communication between Provider and Health Plan's Compliance Officer and participation by Provider in education and training programs regarding the prevention, correction and detection of fraud, waste and abuse and other initiatives identified by CMS. [42 C.F.R.§ 422.112; 42 C.F.R. § 422.504(i)(4)(v); 42 C.F.R. § 422.202(b); 42 C.F.R. § 422.504(a)(5); 42 C.F.R. § 422.503(b)(4)(vi)(C) & (D) & (G)(3).]

I. Delegation (Accountability) Provisions. Provider agrees that to the extent Health Plan, in Health Plan's sole discretion, elects to delegate any administrative activities or functions to First Tier Entity, the following shall apply:

(1) Reporting Responsibilities. The Health Plan and First Tier Entity will agree in writing to a clear statement of such delegated activities and reporting responsibilities relative thereto. [42 C.F.R. § 422.504(i)(3)(ii) and 42 C.F.R. § 422.504(i)(4)(i)]

(2) Revocation. In the event CMS or Health Plan determines that First Tier Entity does not satisfactorily perform the delegated activities and any plan of correction, any and all of the delegated activities may be revoked upon notice by the Health Plan to First Tier Entity. [42 C.F.R. § 422.504(i)(3)(ii) and 42 C.F.R. § 422.504(i)(4)(ii)]

(3) Monitoring. Any delegated activities will be monitored by the Health Plan on an ongoing basis and formally reviewed by the Health Plan at least annually. [42 C.F.R. § 422.504(i)(3)(ii) and 42 C.F.R. § 422.504(i)(4)(iii)]

(4) Credentialing. The credentials of medical professionals, if any, affiliated with Provider and/or First Tier Entity will either be reviewed by Health Plan or, in the event Health Plan has delegated credentialing to First Tier Entity, First Tier Entity's credentialing process will be reviewed and approved by Health Plan, monitored on an ongoing basis and audited at least annually. [42 C.F.R. § 422.504(i)(3)(ii) and 42 C.F.R. § 422.504(i)(4)(iv)]

(5) No Assignment of Responsibility. Provider understands that Provider and/or First Tier Entity may not delegate, transfer or assign any of Provider's or First Tier Entity's obligations with respect to Medicare beneficiaries or any delegation agreement between Health Plan and Provider and/or First Tier Entity without Health Plan's prior written consent.

J. Compliance with Laws and Regulations. Provider agrees to comply with all applicable Medicare laws, rules and regulations, reporting requirements, CMS instructions, and with all other applicable state and federal laws, rules and regulations, as may be amended from time to time including, without limitation: (a) laws, rules and regulations designed to prevent or ameliorate fraud, waste and abuse including, but not limited to, applicable provisions of Federal criminal law, the False Claims Act (31 U.S.C. 3729 et. seq.), and/or the anti-kickback statute (section 1128B(b) of the Act); (b) applicable state laws regarding patients' advance directives as defined in the Patient Self Determination Act (P.L. 101-58), as may be amended from time to time; (c) Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) administrative simplification rules found at 45 C.F.R. parts 160, 162, and 164; and (d) laws, rules and regulations and CMS instructions and guidelines regarding marketing. Additionally, and to the extent applicable, Provider agrees to maintain full participation status in the federal Medicare program and shall ensure that none of its employees, contractors, or subcontractors is excluded from providing services to Medicare beneficiaries under the Medicare program. [42 C.F.R. § 422.204(b)(4) and 42 C.F.R. § 422.752(a)(8)]

(1) Compliance. Provider shall comply with all policies and procedures of Alivi including, without limitation, written standards for the following:

(a) timeliness of access to care and Member services;
(b) policies and procedures that allow for individual medical necessity determinations;
(c) provider consideration of Medicare Advantage Member input into Provider's proposed treatment plan; and
(d) PLAN's compliance program, which encourages effective communication between Provider and PLAN's' compliance officer and participation by Provider and its Professional Staff in education and training programs regarding the prevention, correction and detection of fraud, waste and abuse and other initiatives identified by CMS

(2) Non-Compliance. If performance of a Provider causes non-compliance with state or federal regulatory agencies, Provider shall hold harmless and indemnify Alivi for payment of fines as a result of non-compliance. In addition, Provider agrees to be financially responsible for payment of such fines and shall make payment to Alivi with thirty (30) days' notice. In the event that Provider fails to make payment within timeframe, Alivi, at its discretion, may deduct any amounts owed from Provider reimbursement or payments owed.

K. Accountability. Provider hereby acknowledges and agrees that Health Plan oversees the provision of services by Provider to Medicare beneficiaries and that Health Plan shall be accountable under the Medicare Contract for such services regardless of any delegation of administrative activities or functions to Provider or First Tier Entity. [42 C.F.R. § 422.504(i)(1); (i)(4)(iii); and (i)(3)(ii)]

L. Benefit Continuation. Upon termination of Provider's status as a participating provider with Health Plan (unless such termination was related to safety or other concerns), Provider will continue to provide health care benefits/services to Medicare beneficiaries in a manner that ensures medically appropriate continuity of care and for the time period required by applicable law. Specifically, for Medicare beneficiaries who are hospitalized on the date of such termination, services will be provided through the applicable Medicare beneficiary's date of discharge. In accordance with the requirements of PLAN's accrediting bodies and applicable laws, rules and regulations, Provider will continue to provide Covered Services to Medicare Advantage Members after the termination of this Agreement, whether by virtue of insolvency or cessation of operations of Alivi, or otherwise: (a) for those Medicare Advantage Members who are confined in or admitted to an inpatient facility on the date of termination, until discharge; (b) for all Medicare Advantage Members, through the date for which payments have been made by CMS under the Medicare Advantage Contract; and (c) for those Medicare Advantage Members undergoing active treatment of chronic or acute medical conditions as of the date of termination through their current course of active treatment not to exceed ninety (90) days unless otherwise required. The terms and conditions in the Agreement shall apply to such post- termination Covered Services, and Alivi will pay Provider for such post-termination Covered Services the compensation set out in the applicable Compensation Addendum to the Agreement (excluding administrative fees, potential bonus or shared risk arrangements, if any) or Provider billed charges or the applicable CMS Medicare fee schedule, whichever is less. [42 C.F.R. § 422.504(g)(2)]. The parties acknowledge the provisions set for in this paragraph K are not applicable to NET services.

M. Conscience Protection and Medicare Advantage Member Advice. Nothing in this Agreement will prohibit or otherwise restrict Provider or Provider's Professional Staff, acting within the lawful scope of his, her, or it's field or practice, from advising, or advocating on behalf of a Medicare Advantage Member about:

(a) The Medicare Advantage Member's health status, medical care, or treatment options, including the provision of sufficient information to the individual to provide an opportunity to decide among all relevant treatment options;

(b) The risk, benefits, and consequences of treatment and no treatment; or

(c) The opportunity for the individual to refuse treatment and to express preferences about future treatment decisions.

N. Confidentiality and Accuracy of Medicare Advantage Member Records. For any medical records or other health and enrollment information maintained with respect to Medicare Advantage Members, Provider shall:

(a) Safeguard the privacy of any information that identifies a particular Medicare Advantage Member and generally comply with all obligations under HIPAA. Information from, or copies of, records may be released only to authorized individuals. Provider shall ensure that unauthorized individuals cannot gain access to or alter such records. Medical records must be released only in accordance with federal or state laws, court orders, or subpoenas;

(b) Maintain all such records and information in an accurate and timely manner;

(c) Allow timely access by Medicare Advantage Members to the records and information that pertain to them; and

(d) Abide by all federal and state laws regarding confidentiality and disclosure for mental health records, medical records, other health information, and Medicare Advantage Member information.

O. Federal Funds. Because PLAN under its Medicare Advantage Contract receives federal payments, Provider acknowledges and understands that the PLAN is subject to certain laws that are applicable to individuals and entities receiving federal funds, and that payments received from CMS under the Medicare Advantage Contract are, in whole or in part, federal funds.

P. Non-Discrimination. Neither Provider nor any of Provider's Professional Staff shall discriminate against any Medicare Advantage Member on the basis of race, color, religion, sex, national origin, age, health status, participation in any government program (including Medicare), source of payment, membership in a health maintenance organization, marital status or physical or mental handicap, nor shall Provider knowingly contract with any person or entity which discriminates against any Medicare Advantage Member on any such basis.

Q. Incentive Plans. The parties agree: (i) that nothing contained in the Agreement nor any payment made by ALIVI to Provider is a financial incentive or inducement to reduce, limit or withhold services to Medicare Advantage Members; and (ii) that any incentive plans between Alivi and Provider and/or between Provider and other providers shall be in compliance with applicable state and federal laws, rules and regulations and in accordance with the Medicare Advantage Contract. Upon request, Provider agrees to disclose to Alivi the terms and conditions of any "physician incentive plan" as defined by CMS and/or any state or federal law, rule or regulation. Within thirty (30) days or such lesser period of time required for ALIVI to comply with all applicable state or federal laws, Provider shall disclose to Alivi, upon request by Alivi, execution of this Agreement or creation of a relevant incentive Alivi, all of the terms and conditions of any payment arrangement with respect to its staff, employees or contractors that constitutes a "physician incentive", as defined by CMS and/or any other federal law or regulation. Provider agrees to cooperate with Alivi to make certain that any stop-loss coverage required by law in relation to any physician incentive Alivi's offered by Alivi or Provider is made available. Provider agrees that compensation received from Alivi shall be adjusted by the cost of any stop-loss coverage which Alivi may be required by law to provide.

R. Delegation. In the event PLAN and/or Alivi, elects to delegate any administrative provisions or functions to Provider, Provider acknowledge and agrees that:

(a) Provider may not delegate any of Provider's obligations under the Agreement, this Addendum or any other document without Alivi's written consent;

(b) Provider must demonstrate Provider's ability to perform such delegated duty to ALIVI's satisfaction;

(c) Provider and Alivi must set down in writing (i) the specific functions delegated; (ii) the reporting obligations of Provider pursuant to Alivi's policies and procedures or the Medicare Advantage Contract; (iii) the scope of Alivi's oversight and supervisory functions under the agreement of delegation; and (iv) any corrective action measures, including the termination or suspension of the delegated functions if Alivi or CMS determines that such delegated activities have not been adequately performed. Services of any delegates or subcontractors will be subject to monitoring by Alivi on an ongoing basis. Alivi retains the right to approve, suspend or terminate the subcontract or delegation.

S. Other Provider shall document the existence of an advance directive in a prominent place in all applicable Medicare Advantage Member patient records in compliance with the Patient Self-Determination Act (P.L. 101-508), as amended and to the extent applicable, and other applicable laws. Provider shall provide Covered Services to Medicare Advantage Members in a manner consistent with professionally recognized standards of health care. To assist PLAN in fulfilling its duty to provide written notice of the termination of Provider within fifteen (15) working days to all Medicare Advantage Members who are patients seen on a regular basis by Provider, Provider shall provide to Alivi and/or PLAN a list of such Medicare Advantage Members specific to Provider within fifteen (15) days. Provider shall arrange for the provision of or make

available Covered Services to Medicare Advantage Members on a twenty-four (24) hour basis. Provider shall arrange telephone coverage after regular office hours and arrange for appropriate instructions as to how and where to obtain such Covered Services from others in the event Provider is unavailable, in order to assure that the life or safety of a Medicare Advantage Member will not be jeopardized. Provider acknowledge and agree that Alivi shall oversee the provision of Covered Services to Medicare Advantage Members under the Agreement and shall be accountable and bear ultimate responsibility under the Medicare Advantage Contract for the provision of such Covered Services, regardless of the provisions of the Agreement or the delegation of duties or the delegation of any administrative functions under the Agreement; provided that the foregoing shall no limit or restrict Provider's obligations under the Agreement, including any delegation of duties thereunder. Alivi and/or PLAN shall monitor Provider's performance on an ongoing basis.

Section 7 - Vehicle Inspection Form

Company or Driver Full Name		Signature
Email Address	Phone Number	Date

EXTERIOR INSPECTION POINTS	PASS	FAIL	INTERIOR INSPECTION POINTS	PASS	FAIL
STEERING MECHANISM	☐	☐	INTERIOR CONDITION	☐	☐
WINDSHIELD	☐	☐	EMERGENCY PARKING BRAKE	☐	☐
REAR WINDOW AND OTHER GLASS	☐	☐	HORN	☐	☐
MUFFLER AND EXHAUST	☐	☐	SPEEDOMETER	☐	☐
FLUID LEVELS	☐	☐	AIR-CONDITIONING AND HEATING	☐	☐
TIRES	☐	☐	SAFETY BELTS & 2 EXTENSIONS	☐	☐
Right Front	☐	☐	FRONT SEAT ADJUSTMENT MECHANISM	☐	☐
Left Front	☐	☐	WINDSHIELD WIPERS	☐	☐
Right Rear	☐	☐	REAR VIEW MIRROR	☐	☐
Left Rear	☐	☐	SPARE TIRE	☐	☐
LOW AND HIGH BEAM HEADLIGHTS	☐	☐	TIRE CHANGING EQUIPMENT	☐	☐
BRAKE AND TAIL LIGHTS	☐	☐	SIGNS – NO SMOKING, SEATBELT	☐	☐
BACK-UP LIGHTS	☐	☐	**SAFETY KIT**	☐	☐
EMERGENCY HAZARD LIGHTS	☐	☐	VEHICLE MANUAL		
FRONT AND REAR TURN INDICATORS	☐	☐	ACCIDENT REPORT FORMS	☐	☐
BUMPERS	☐	☐	ROADSIDE REFLECTORS	☐	☐
DOORS (open, close and lock)	☐	☐	SEATBELT CUTTER	☐	☐
LEFT SIDE MIRROR	☐	☐	WINDOW GLASS BREAKER	☐	☐
RIGHT SIDE MIRROR	☐	☐	SPILL KIT	☐	☐
EXTERIOR CONDITION	☐	☐	FIRST AID KIT	☐	☐

VEHICLE INSPECTION RESULTS

☐ **PASS** ☐ **FAIL** INSPECTION DATE ☐

Any marking on the "FAIL" side will automatically fail inspection. THIS CERTIFICATION EXPIRES 1 YEAR FROM INSPECTION DATE.

Vehicle Mileage	License Plate State & Number	VIN
Vehicle Make	Vehicle Model	Number of Doors
Vehicle Color	Vehicle Type	Seat Capacity
Inspection Company Name	Inspection Company Address	
Inspector Signature	Inspector Name	State Certification Number

Notes:_____

_____

Additional Inspection Points for Multi-Purpose Vehicles

MULTI-PURPOSE VEHICLES MUST PASS ALL GENERAL INSPECTION POINTS AND THE FOLLOWING INSPECTION POINTS:

INSPECTION POINT - WHEELCHAIR	PASS	FAIL
INSIDE MIRROR	☐	☐
WHEELCHAIR LOCKDOWNS – 4 PER WHEELCHAIR	☐	☐
SEALED FLOOR	☐	☐
INTERIOR HEIGHT 56”	☐	☐
ENGINE-WHEELCHAIR LIFT INTERLOCK SYSTEM	☐	☐
RAMP FUNCTIONAL	☐	☐
LIFT PLATFORM		
30 in x 48 in	☐	☐
Smooth operation	☐	☐
No sharp edges	☐	☐
Anti-roll-off barrier	☐	☐
Hand rail on both sides	☐	☐
WHEELCHAIR ENTRANCE DOOR	☐	☐
56in x 30 in	☐	☐
Device to lock door in place	☐	☐
INSPECTION POINT – STRETCHER		
LITTER FASTENERS	☐	☐
2 RESTRAINTS PER LITTER	☐	☐
INSIDE MIRROR	☐	☐
LATCHING DEVICES	☐	☐
SEALED FLOOR	☐	☐
INTERIOR HEIGHT 55”	☐	☐
SAFETY KIT		
FLASHLIGHT	☐	☐
FIRE EXTINGUISHER – ABC 10 LB.	☐	☐

MULTI-PURPOSE VEHICLE INSPECTION RESULTS

☐ **PASS** ☐ **FAIL** INSPECTION DATE _____

Any marking on the “FAIL” side will automatically fail inspection. THIS CERTIFICATION EXPIRES 1 YEAR FROM INSPECTION DATE.

Notes:_____

_____

_____

_____

Date of Incident _____

Member/Recipient Information

Name of Primary Person(s) Involved in Incident			
Member Medicaid/ID # (if applicable)	Health Plan	Age	Phone #
Residential Address			

Location of Incident

Address of Incident (if different from above)		
Transportation Provider Name	Phone #	Driver Name

Other Recipients/Members Involved

Name	Date of Birth
Name	Date of Birth
Name	Date of Birth

Staff Involved

Name			Title
Name			Title
Name of Person Reporting the Incident	Phone #	Fax #	Title

Section 1: Incident Categorization

Serious Reportable (report to be submitted within 24 hours)

- ☐ Death
- ☐ Allegarion of Abuse
- ☐ Neglect
- ☐ Serious Physical Injury
- ☐ Theft of Personal Property or Funds of Customers
- ☐ Serious Medication Error
- ☐ Improper Use of Restrants
- ☐ Emergency Impatient Hospitalization
- ☐ Suicide Attemp or Threat
- ☐ Missing Person
- ☐ Incident Requiring Law Enforcement or Emergency Personnel
- ☐ Aspiration

Alleged Abuse Neglect Categories

a. Physical
b. Sexual
c. Verbal
d. Psychological
e. Self Abuse
f. Mistreatment
g. Exploitation
h. Individual-Individual

For abuse and neglect allegations, staff must be removed from ALL customer contact inmediatedly.

Please indicate below that this action has been taken.

Name of Supervisor certifying that action has been taken (print)

Title _____

Signature _____

Reportable

(report written maintined in-house for internal investigation and trending/tracking report)

- ☐ Property Damage
- ☐ Medication Error
- ☐ Suicide Threat (BSP)
- ☐ Hospitalization
- ☐ Physical Injury
- ☐ Vehicle Accident
- ☐ Theft by an Individual of Individual's Funds/Property
- ☐ Ingestion of Harmful Substance
- ☐ Overuse of Chemical Restraints
- ☐ Burns
- ☐ Bloodborne Pathogens Exposure

Primary Location

- ☐ Residential Facility Circle (ICF) (CRF)
- ☐ Day Treatment Program
- ☐ Community Outing
- ☐ Transportation Vehicle
- ☐ Natural Home
- ☐ Hospital
- ☐ Nursing Home
- ☐ Other

Fax to Alivi within 24 hours of accident/Incident: 305.402.0980

Date of Incident _____

Section 2: Description of Incident (Check or complete, as appropriate)

Date of Incident	Time	
	☐ AM ☐ PM	☐ Informed ☐ Witnessed ☐ Discovered

Reporter Code

☐ 1. Employee ☐ 2. Facility ☐ 3. Family ☐ 4. Visitor ☐ 5. Other (Name)

Witness Name	Witness Phone Number
Witness Name	**Witness Phone Number**

Description of the Incident (Please provide all information in a clear and concise manner - use additional pages as necessary)

Immediate Actions Taken (Include what actions were taken and by whom, i.e. medical treatment provided)

☐ Investigation Initiated	By Whom	Investigator

Signature of Reporter	Date	Time
		☐ AM ☐ PM

Corrective Action Plan

Verbal Notification (Check All That Apply)	Person Notified	Date	Time
☐ Case Manager			
☐ Alivi			
☐ Family/Guardian (unless otherwise documented)			
☐ Nurse/Physician			
☐ Adult or Child Protective Services			
☐ Legal Representative Attorney			
☐ Police Department/MPD Report Number_____			

Driver Signature	Management/Owner Signature	Alivi Signature or applicable

Fax to Alivi within 24 hours of accident/Incident: 305.402.0980