STATE SETTLEMENT AGREEMENT

I. PARTIES

This Settlement Agreement ("Agreement") is entered into between the State of Florida ("the State") and CareCore National, LLC ("CareCore"), hereinafter collectively referred to as "the Parties," through their authorized representatives.

II. PREAMBLE

As a preamble to this Agreement, the Parties agree to the following:

A. At all relevant times, CareCore, a Delaware limited liability company with its principal place of business in Bluffton, South Carolina, provided outpatient diagnostic testing and procedure utilization management services, including pre-authorization/pre-certification determinations of medical necessity for beneficiaries enrolled in the State's Medicaid program.

B. On February 21, 2013, John Miller ("Relator") filed a *qui tam* complaint in the United States District Court for the Southern District of New York captioned *United States of America et al., ex. rel Miller v. CareCore National, LLC, et al.*, Civil Action No. 13-cv-1177 and on November 18, 2014, Relator filed an amended complaint (the "Civil Action").

C. CareCore has entered into a separate civil settlement agreement (the "Federal Settlement Agreement") with the United States of America (as that term is defined in the Federal Settlement Agreement) hereinafter referred to as the "United States."

D. The State contends that CareCore caused claims for payment to be submitted to the State's Medicaid program (see 42 U.S.C. §§ 1396-1396(w-5)). Claims may be submitted to the State's Medicaid program directly or through an intermediary, commonly known as a managed care organization ("MCO"). MCOs are contractors with the State's Medicaid program and the submission of claims for payment to an MCO constitutes the submission of claims to the State's Medicaid Program.

E. The State contends that it has certain civil and administrative causes of action against CareCore for engaging in the following conduct (the "Covered Conduct"):

The State alleges that from January 1, 2005 through June 13, 2013, CareCore developed and implemented the Process As Directed or "PAD" Program through which CareCore improperly approved over two hundred thousand prior authorization requests, an action known at CareCore as "padding;" this practice involved approving prior authorization requests, which CareCore initially determined could not be approved based on the information provided. This practice caused false or fraudulent claims to be submitted to and reimbursed by the State's Medicaid program, including its contracted MCOs, for procedures that were not properly authorized as medically reasonable or necessary in a manner consistent with the policies and procedures set forth by the State's Medicaid program and its contracted MCOs, using federal and State funds provided through Medicaid Managed Care. As a result of the foregoing conduct, the State alleges that CareCore violated the False Claims Act, 31 U.S.C. 3729 *et seq.*, and relevant State laws.

F. CareCore admits to the facts as set forth in Exhibit A, attached to this Agreement.

G. To avoid the delay, expense, inconvenience, and uncertainty of protracted litigation of these causes of action, the Parties mutually desire to reach a full and final settlement as set forth below.

III. TERMS AND CONDITIONS

NOW, THEREFORE, in reliance on the representations contained herein and in consideration of the mutual promises, covenants and obligations set forth in this Agreement, and for good and valuable consideration as stated herein, the Parties agree as follows:

1. CareCore agrees to pay to the United States and the Medicaid Participating States (as defined in sub-paragraph (c) below), collectively, the sum of $54,000,000.00, plus accrued interest on that amount of 1.75% per annum commencing on October 27, 2016 and continuing to and including the day payment is made under this Agreement (collectively, the "Settlement Amount"). The Settlement Amount shall constitute a debt immediately due and owing to the United States and the Medicaid Participating States on the Effective Date of the Federal Settlement Agreement, and subject to the terms of this Agreement. The debt shall forever be discharged by payments to the United States and the Medicaid Participating States, under the following terms and conditions:

(a) CareCore shall pay to the United States the sum of $45,000,000.00, plus accrued interest as set forth above ("Federal Settlement Amount"). The Federal

Settlement Amount shall be paid pursuant to the terms of the Federal Settlement Agreement.

(b) CareCore shall pay to the Medicaid Participating States the sum of $9,000,000.00 plus accrued interest as set forth above ("Medicaid State Settlement Amount"), subject to the non-participating state deduction provision of Sub-paragraph (d) below ("Medicaid Participating State Settlement Amount"), no later than seven (7) business days after the expiration of the 60-day opt-in period for Medicaid Participating States described in Sub-paragraph (c) below. The Medicaid Participating State Settlement Amount shall be paid by electronic funds transfer to the New York State Attorney General's National Global Settlement Account pursuant to written instructions from the State Negotiating Team ("State Team"), which written instructions shall be delivered to counsel for CareCore.

(c) CareCore shall execute a State Settlement Agreement with any State that executes such an Agreement in the form to which CareCore and the State Team have agreed or in a form otherwise agreed to by CareCore and an individual State. The State shall constitute a "Medicaid Participating State" provided this Agreement is fully executed by the State and delivered to CareCore's attorneys within 60 days of receiving this Agreement. If this condition is not satisfied within 60 days, CareCore's offer to resolve this matter with the individual State shall become null and void absent written agreement between counsel for CareCore and the State Team to extend the 60-day period.

(d) The total portion of the amount paid by CareCore in settlement for the Covered Conduct for the State is $1,442,394.38, consisting of a portion paid to

the State under this Agreement and another portion paid to the United States as part of the Federal Settlement Agreement. The amount allocated to the State under this Agreement is the sum of $617,227.96, plus applicable interest (the "State Amount"). If the State does not execute and deliver this Agreement within 60 days of receipt, the State Amount shall be deducted from the Medicaid State Settlement Amount and shall not be paid by CareCore absent written agreement between counsel for CareCore and the State Team to extend the time period for executing this Agreement.

2. Conditioned on CareCore making the payments described in Paragraph 1(d) above, the State agrees to dismiss with prejudice any state law claims which the State has the authority to dismiss currently pending against CareCore in State or Federal Courts for the Covered Conduct, including any supplemental state law claims asserted in the Civil Action. Contingent upon receipt of the State Amount, the State, if served in the Civil Action and liable to pay a Relator's share, agrees to pay the Relator, as soon as feasible after such receipt, such amounts, including applicable interest, as have been or will be negotiated with the Relator in the Civil Action, which shall be set forth in side letters issued to and executed by the Relator in the Civil Action. The Relator's share is to be paid through the State Team.

3. Subject to the exceptions in Paragraph 4 below, in consideration of the obligations of CareCore set forth in this Agreement, and conditioned upon receipt by the State of its share of the Medicaid State Settlement Amount, the State agrees to release CareCore from any civil or administrative monetary cause of action that the State has for

any claims submitted or caused to be submitted to the State Medicaid Program, including its contracted MCOs, as a result of the Covered Conduct.

4. Notwithstanding the releases given in Paragraph 3 of this Agreement, or any other term of this Agreement, the following claims of the State are specifically reserved and are not released:

(a) any criminal, civil, or administrative liability arising under state revenue codes;

(b) any criminal liability not specifically released by this Agreement;

(c) any civil or administrative liability that any person or entity, including any Released Entities, has or may have to the State or to individual consumers or state program payors under any statute, regulation or rule not expressly covered by the release in Paragraph 3 above, including but not limited to, any and all of the following claims: (i) State or federal antitrust violations; (ii) Claims involving unfair and/or deceptive acts and practices and/or violations of consumer protection laws;

(d) any liability to the State for any conduct other than the Covered Conduct;

(e) any liability based upon obligations created by this Agreement;

(f) except as explicitly stated in this Agreement, any administrative liability, including mandatory exclusions from the State's Medicaid program;

(g) any liability for expressed or implied warranty claims or other claims for defective or deficient products and services, including quality of goods and services;

(h) any liability for personal injury or property damage or for other consequential damages arising from the Covered Conduct;

(i) any liability for failure to deliver goods or services due; or

(j) any liability of individuals.

5. CareCore waives and shall not assert any defenses it may have to criminal prosecution or administrative action for the Covered Conduct, which defenses may be based in whole or in part on a contention, under the Double Jeopardy Clause of the Fifth Amendment of the Constitution or the Excessive Fines Clause of the Eighth Amendment of the Constitution, that this Agreement bars a remedy sought in such criminal prosecution or administrative action.

6. In consideration of the obligations of the State set forth in this Agreement, CareCore waives and discharges the State, its agencies, employees, and agents from any causes of action (including attorneys' fees, costs, and expenses of every kind and however denominated) which CareCore has against the State, its agencies, employees, and agents arising from the State's investigation and prosecution of the Covered Conduct.

7. The amount that CareCore must pay to the State pursuant to Paragraph III.1. above will not be decreased as a result of the denial of any claims for payment now being withheld from payment by the State's Medicaid program, or any other state payor, for the Covered Conduct; and CareCore agrees not to resubmit to the State's Medicaid program, including any MCO which may be under contract to the State's Medicaid program, or any other state payor, claims previously denied based on the Covered Conduct, and agrees to withdraw the appeal of or not to appeal or cause the appeal of any such denials of claims.

8. CareCore shall not seek payment for any claims for reimbursement to the State's Medicaid Program, including its contracted MCOs, covered by this Agreement from any health care beneficiaries or their parents, sponsors, legally responsible individuals, or third party payors.

9. CareCore expressly warrants that it has reviewed its financial condition and that it is currently solvent within the meaning of 11 U.S.C. §§ 547(b)(3) and 548(a)(1)(B)(ii)(I), and shall remain solvent following payment of the Settlement Amount and compliance with this Agreement.

10. The Parties each represent that this Agreement is freely and voluntarily entered into without any degree of duress or compulsion whatsoever.

11. CareCore agrees to cooperate fully and truthfully with any State investigation of individuals or entities not released in this Agreement. Upon reasonable notice, CareCore shall encourage, and agrees not to impair, the cooperation of its directors, officers, and employees, and shall use its best efforts to make available and encourage, the cooperation of former directors, officers and employees for interviews and testimony, consistent with the rights and privileges of such individuals and of CareCore. Upon request, CareCore agrees to furnish to the State complete and unredacted copies of all non-privileged documents including, but not limited to, reports, memoranda of interviews, and records in its possession, custody or control, concerning the Covered Conduct that it has undertaken, or that has been performed by another on its behalf. CareCore shall be responsible for all costs it may incur in complying with this paragraph.

12. Except as expressly provided to the contrary in this Agreement, each Party to this Agreement shall bear its own legal and other costs incurred in connection with this matter, including the preparation and performance of this Agreement.

13. Except as otherwise stated in this Agreement, this Agreement is intended to be for the benefit of the Parties only, and by this instrument the Parties do not release any liability against any other person or entity.

14. Nothing in this Agreement constitutes an agreement by the State concerning the characterization of the amounts paid hereunder for purposes of the State's revenue code.

15. In addition to all other payments and responsibilities under this Agreement, CareCore agrees to pay all reasonable expenses and travel costs of the State Team, including reasonable consultant fees and expenses. CareCore will pay this amount by separate check made payable to the National Association of Medicaid Fraud Control Units, after the Medicaid Participating States execute their respective Agreements, or as otherwise agreed by the Parties.

16. This Agreement is governed by the laws of the State, and venue for addressing and resolving any and all disputes relating to this Agreement shall be the State courts of appropriate jurisdiction of the State.

17. The undersigned CareCore signatories represent and warrant that they are authorized as a result of appropriate corporate action to execute this Agreement. The undersigned State signatories represent that they are signing this Agreement in their

official capacities and that they are authorized to execute this Agreement on behalf of the State through their respective agencies and departments.

18. The Effective Date of this Agreement shall be the date of signature of the last signatory to this Agreement. Facsimiles of signatures shall constitute acceptable binding signatures for purposes of this Agreement.

19. This Agreement shall be binding on all successors, transferees, heirs, and assigns of the Parties.

20. This Agreement constitutes the complete agreement between the Parties with respect to this matter and shall not be amended except by written consent of the Parties.

21. This Agreement may be executed in counterparts, each of which shall constitute an original, and all of which shall constitute one and the same Agreement.

[Signature pages follow]

STATE OF FLORIDA

The State of Florida
Office of the Attorney
Medicaid Fraud Control Unit

By: _____ Dated: 5/8/17
Patricia A. Conners
Chief Deputy Attorney General

CARECORE NATIONAL, LLC

By: _____ Dated: 6/14/17

[Name] Philip S. Clark
[Title] General Counsel

By: _____ Dated: 6-14-17

Counsel to CareCore National, LLC

EXHIBIT A

1. CareCore admits, acknowledges, and accepts responsibility for the following conduct that occurred between January 1, 2005 and June 13, 2013:

a. CareCore provides services to health insurers, including managed care organizations that provide services to beneficiaries of the Medicare Part C and Medicaid programs (collectively, "MCOs"). CareCore provides prior authorization services, as directed by contracts with individual MCOs, which consist of screening prior authorization requests for certain procedures made by treating physicians on behalf of beneficiaries for medical reasonableness and necessity based on objective medical criteria in a manner consistent with the policies and procedures of applicable State Medicaid programs and the MCOs. During the times pertinent to this matter, CareCore's Clinical Reviewers, who generally were nurses, received information from the treating physicians and input that information into CareCore's proprietary software system. That software system, based on the information provided, either recommended approval of the prior authorization or recommended further review by a physician.

b. Under the applicable regulations and/or contractual provisions, if a plan decides to implement prior medical necessity review in order to cover physician-ordered services, only a physician or other appropriate health care professional with sufficient expertise has the authority to deny a procedure. Thus, if a prior authorization could not be issued based on the information currently supplied by the treating physician, the prior authorization request, including all of the related information, was placed in an electronic queue, the Medical Review Queue. The prior authorization request could be accessed in the Medical Review Queue by a CareCore Medical Director, who is a physician retained by CareCore, and who would review the information and determine whether to conduct a peer call with the treating physician or appraise information gathered after the initial request in

order to determine whether prior authorization of the procedure was appropriate, or should be denied.

c. In order for the MCOs to meet timelines in the applicable regulations and/or pursuant to its contractual obligations and provisions, CareCore was required to issue a determination on prior authorization requests within fixed time periods known as "Turn Around Times," or "TATs", often as little as four hours for urgent requests, and 48 hours for non-urgent requests. CareCore was also subject to contractual monetary penalties if it failed to maintain performance standards, including meeting the processing deadlines set forth in the regulations and contracts.

d. Starting in at least 2007, CareCore developed the "Process As Directed", or "PAD", Program. Under the PAD Program, CareCore's Clinical Reviewers would approve certain prior authorization requests awaiting physician review on the Medical Review Queue that had been on the queue for nearly the entire applicable TAT for processing the prior authorization request. The PAD Program consisted of Clinical Reviewers improperly approving certain prior authorization requests on the Medical Review Queue without having obtained any new objective medical information about the request, and without a Medical Director having independently reviewed the prior authorization request. These prior authorization requests ("padded requests") were then transmitted to CareCore's client insurers, including MCOs, as preauthorized requests.

e. In 2007, the PAD Program was formalized into corporate policy, which included detailed training materials and daily reporting of the number of padded requests to high-level executives then- employed at CareCore. When daily regular review of the Medical Review Queue showed the volume of cases in the Medical Review Queue was too high to make a timely decision for a significant volume of requests for prior authorization, certain Clinical Reviewers were directed by then-

management to approve requests for prior authorization without obtaining or considering any new medical information.

f. From 2007 through June 13, 2013, CareCore padded between two and three hundred thousand prior authorization requests.

g. In CareCore's role managing the prior authorization process, it had medical information of the beneficiaries seeking prior authorization. When CareCore approved padded requests, CareCore made a representation that it had appropriately reviewed the requests when it knew it had not. Thus, those padded requests incorporated CareCore's false representation that it had approved a case after completing the required review process. The MCOs thereafter provided coverage based on CareCore's approval of the prior authorizations.

h. MCOs would only pay for procedures that require a prior authorization if the prior authorization was granted in a manner consistent with the MCO's policies and procedures. Thus, the PAD Program resulted in insurance claims related to the padded requests being presented to the MCOs for payment with federal and/or state government funds, and MCOs actually paid insurance claims made in connection with the padded requests.