This Appendix is subject to review and approval by the Missouri State Medicaid Agency.

MEDICAID AND CHIP REGULATORY REQUIREMENTS APPENDIX

DOWNSTREAM PROVIDER

THIS MEDICAID AND CHIP REGULATORY REQUIREMENTS APPENDIX (this "Appendix") supplements and is made part of the provider agreement (the "Agreement") between Ear Professionals International Corporation d/b/a EPIC Hearing Healthcare and d/b/a UnitedHealthcare Hearing ("Subcontractor") and the provider named in the Agreement ("Provider").

SECTION 1
APPLICABILITY

This Appendix applies with respect to the provision of health care services that Provider provides directly to Covered Persons through Health Plan's (as defined herein) products or benefit plans under the State's Medicaid and/or CHIP program (the "State Program") as governed by the State's designated regulatory agencies. Provider has agreed to provide Covered Services to Covered Persons who receive their coverage pursuant to a contract between the State and Health Plan (the "State Contract" as defined herein). The State Contract and applicable State and federal law require that the provisions contained in this Appendix be part of the Agreement. In the event of a conflict between this Appendix and other appendices or any provision of the Agreement, the provisions of this Appendix shall control except with regard to benefit plans outside the scope of this Appendix or unless otherwise required by law. In the event Subcontractor is required to amend or supplement this Appendix as required or requested by the State, Provider agrees that Subcontractor shall be permitted to unilaterally initiate such additions, deletions or modifications.

SECTION 2
DEFINITIONS

Unless otherwise defined in this Appendix, all capitalized terms shall be as defined in the Agreement. For purposes of this Appendix, the following terms shall have the meanings set forth below; provided, however, in the event any definition set forth in this Appendix or the Agreement is inconsistent with any definitions under the applicable State Program, the definitions shall have the meaning set forth under the applicable State Program.

2.1 **Children's Health Insurance Program or CHIP:** A program authorized by Title XXI of the federal Social Security Act that is jointly financed by the federal and State governments and administered by the State.

2.2 **Covered Person:** An individual who is currently enrolled with Health Plan for the provision of services under a State Program. A Covered Person may also be referred to as an Enrollee, Member or Customer under the Agreement.

2.3 **Covered Services:** Health care services or products for which a Covered Person is enrolled with Health Plan to receive coverage under a State Contract.

2.4 **Department:** The State agency(ies) responsible for administering the State Program.

2.5 **Health Plan:** An appropriately licensed entity that has entered into a contract with Subcontractor, either directly or indirectly, under which Subcontractor provides certain administrative services for Health Plan pursuant to the State Contract. For purposes of this Appendix, Health Plan refers to <<Insert Legal Entity>>.

2.6 **Medicaid:** A program authorized by Title XIX of the federal Social Security Act, and jointly financed by the federal and State governments and administered by the State.

2.7 **State:** The State administering the applicable Medicaid and/or CHIP program or its designated regulatory agencies.

2.8 **State Contract:** A contract between Health Plan and a Department for the purpose of providing and paying for Covered Services to Covered Persons enrolled in the State Program.

2.9 **State Program:** The Medicaid and/or CHIP program developed and administered by the State. For purposes of this Appendix, State Program may refer to the State agency(ies) responsible for administering the applicable State Program.

SECTION 3
PROVIDER REQUIREMENTS

The State Program, through contractual requirements and federal and State statutes and regulations, requires the Agreement to contain certain conditions that Subcontractor, Health Plan and Provider agree to undertake, which include the following:

3.1 **Definitions Related to the Provision of Covered Services.** Provider shall follow the applicable State Contract's requirements for the provision of Covered Services. Provider's decisions affecting the delivery of acute or chronic care services to Covered Persons shall be made on an individualized basis and in accordance with the following definitions:

(a) Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: (1) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to body functions; or (3) serious dysfunction of any body organ or part.

(b) Emergency Services: Covered inpatient and outpatient services furnished by a provider qualified to furnish those health services and that are needed to evaluate or stabilize an Emergency Medical Condition.

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(c) Medically Necessary or Medical Necessity: Services provided in accordance with 42 CFR Section 438.210(a)(4), as may be amended from time to time, to include that medical or allied care, goods, or services furnished or ordered and which meet the following conditions:

(i) Necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain;
(ii) Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
(iii)Consistent with the generally accepted medical standards as determined by the State Program, and not experimental or investigational;
(iv)Reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available, statewide; and
(v) Furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the Provider.

"Medically Necessary" or "Medical Necessity" for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of the appropriate medical care, be effectively furnished more economically on an outpatient basis or by an inpatient Provider of a different type. The fact that Provider has prescribed, recommended or approved medical or allied goods, or services does not, in itself, make such care, goods or services Medically Necessary or a Medical Necessity or a Covered Service.

3.2 **Medicaid or CHIP Participation.** Provider must be enrolled with the State as a Medicaid or CHIP provider, as applicable to participate in Subcontractor's Medicaid or CHIP network. Upon notification from the State that Provider's enrollment has been denied or terminated, Subcontractor must terminate Provider immediately and will notify affected Covered Persons that Provider is no longer participating in the network. Subcontractor will exclude from its network any provider who is on the State's exclusion list or has been terminated or suspended from the Medicare, Medicaid or CHIP program in any state.

3.3 **Accessibility Standards.** Provider shall provide for timely access for Covered Person appointments in accordance with the appointment availability requirements established under the State Contract, as further described in the applicable provider manual.

3.4 **Hours of Operation; Appointments.** Provider shall offer hours of operation that are no less than the hours of operation offered to commercial beneficiaries or comparable to Medicaid fee-for-service if Provider serves only Medicaid beneficiaries. As applicable, Provider will make Covered Services available 24 hours a day, 7 days a week when medically necessary.

3.5 **Hold Harmless.** Except for applicable cost-sharing requirements under the State Contract, Provider shall look solely to Subcontractor or Health Plan, as applicable, for payment of Covered Services provided to Covered Persons pursuant to the Agreement and the State Contract and hold the State, the U.S. Department of Health and Human Services and Covered Persons harmless in the event that Subcontractor and/or Health Plan cannot or will not pay for

such Covered Services. In accordance with 42 CFR Section 447.15, as may be amended from time to time, the Covered Person is not liable to Provider for any services for which Subcontractor and/or Health Plan is liable and as specified under the State's relevant health insurance or managed care statutes, rules or administrative agency guidance. Provider shall not require any copayment or cost sharing for Covered Services provided under the Agreement unless expressly permitted under the State Contract. Provider shall also be prohibited from charging Covered Persons for missed appointments if such practice is prohibited under the State Contract or applicable law. This provision shall survive any termination of the Agreement, including breach of the Agreement due to insolvency.

3.6 **Indemnification.** To the extent applicable to Provider in performance of the Agreement, Provider shall indemnify, defend and hold the Department and Covered Persons harmless from and against all claims, damages, causes of action, costs or expenses, including court costs and attorney fees, to the extent proximately caused by any negligent act or other wrongful conduct arising from the Agreement. This clause shall survive the termination of the Agreement for any reason, including breach due to insolvency. The Department may waive this requirement for itself, but not for Covered Persons, for damages in excess of the statutory cap on damages for public entities if Provider is a state agency or sub-unit as defined by the State or a public health entity with statutory immunity. All such waivers must be approved in writing by the Department.

3.7 **Provider Selection.** To the extent applicable to Provider in performance of the Agreement, Provider shall comply with 42 CFR 438.214, as may be amended from time to time, which includes, but is not limited to the selection and retention of providers, credentialing and recredentialing requirements and nondiscrimination. If Subcontractor and/or Health Plan delegates credentialing to Provider, Subcontractor and Health Plan will provide monitoring and oversight and Provider shall ensure that all licensed medical professionals are credentialed in accordance with Subcontractor's, Health Plan's and the State Contract's credentialing requirements.

3.8 **Restrictions on Referrals.** Provider shall not make inappropriate referrals for designated health services to health care entities with which Provider or a member of Provider's family has a financial relationship, pursuant to federal anti-kickback and physician self-referral laws that prohibit such referrals.

3.9 **Subcontracts.** If Provider subcontracts or delegates any functions of the Agreement, in accordance with the terms of the Agreement, the subcontract or delegation must be in writing and include all of the requirements of this Appendix, applicable requirements of the State Contract, and applicable laws and regulations. Provider further agrees to promptly amend its agreements with such subcontractors, in the manner requested by Subcontractor or Health Plan, to meet any additional State Program requirements that may apply to the services. United shall maintain ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State.

3.10 **Records Retention.** As required under State or federal law or the State Contract, Provider shall maintain an adequate record keeping system for recording services, charges, dates

and all other commonly accepted information elements for services rendered to Covered Persons. All financial records shall follow generally accepted accounting principles. Medical records and supporting management systems shall include all pertinent information related to the medical management of each Covered Person. Other records shall be maintained as necessary to clearly reflect all actions taken by Provider related to services provided under the State Contract. Provider shall retain all records including, as applicable, grievance and appeal records and any other records related to data, information, and documentation for a period of not less than 10 years from the close of the Agreement, or such other period as required by law. If records are under review or audit, they must be retained for a minimum of 10 years following resolution of such action. Prior approval for the disposition of records must be requested and approved by Subcontractor and Health Plan if the Agreement is continuous.

3.11 **Records Access.** Provider acknowledges and agrees that the State, the U.S. Department of Health and Human Services and other authorized federal and state personnel shall have complete access to all records pertaining to services provided to Covered Persons. Provider shall provide immediate access to facilities, records and supportive materials pertinent to the State Contract for State or Federal fraud investigators.

3.12 **Government Audit; Investigations.** Provider acknowledges and agrees that the State, CMS, the Office of Inspector General, the Comptroller General, and the U.S. Department of Health and Human Services and their designees or their authorized representatives shall at any time, have the right to inspect, audit or otherwise evaluate the quality, appropriateness, and timeliness of services provided under the terms of the State Contract and any other applicable rules, including the right to inspect and audit any records, books, contracts, computers or other electronic systems or documents of Provider and its subcontractors, and the right to inspect the premises, physical facilities, equipment where Medicaid-related activities or work is conducted. The right to audit under this section exists for 10 years from the end date of the State Contract or from the date of completion of any audit, whichever is later.There shall be no restrictions on the right of the State or federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness or timeliness of services provided pursuant to the State Contract and the reasonableness of their costs.

3.13 **Privacy: Confidentiality.** Provider understands that the use and disclosure of information concerning Covered Persons is restricted to purposes directly connected with the administration of the State Program and shall maintain the confidentiality of Covered Person's information and records as required by the State Contract and in federal and State law including, but not limited to, all applicable privacy, security and Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Public Law 104-191, and associated implementing regulations, including but not limited to 45 CFR Parts 160, 162, 164, as applicable and as may be amended from time to time, and shall safeguard information about Covered Persons in accordance with applicable federal and State privacy laws and rules including but not limited to 42 CFR §438.224, 42 CFR Part 2, and 42 CFR Part 431, Subpart F; 42 CFR Part 434 and 42 CFR 438.6 (if applicable), as may be amended from time to time.

Access to member identifying information shall be limited by Provider to persons or agencies that require the information in order to perform their duties in accordance with this Agreement, including the U.S. Department of Health and Human Services (HHS), the Department and other individuals or entities as may be required. (See 42 CFR §431.300, et seq. and 45 CFR Parts 160 and 164.) Any other party shall be granted access to confidential information only after complying with the requirements of state and federal laws, including but not limited to HIPAA, and regulations pertaining to such access. Provider is responsible for knowing and understanding the confidentiality laws listed above as well as any other applicable laws. Nothing herein shall prohibit the disclosure of information in summary, statistical or other form that does not identify particular individuals, provided that de-identification of protected health information is performed in compliance with the HIPAA Privacy Rule.

Federal and State Medicaid regulations, and some other federal and State laws and regulations, including but not limited to those listed above, are often more stringent than the HIPAA regulations. Provider shall notify Subcontractor, Health Plan and the Department of any breach of confidential information related to Covered Persons within the time period required by applicable federal and State laws and regulations following actual knowledge of a breach, including any use or disclosure of confidential information, any breach of unsecured PHI, and any Security Incident (as defined in HIPAA regulations) and provide Subcontractor, Health Plan and the Department with an investigation report within the time period required by applicable federal and State laws and regulations following the discovery. Provider shall work with Subcontractor, Health Plan and the Department to ensure that the breach has been mitigated and reporting requirements, if any, complied with.

3.14 **Compliance with Law.** Provider shall comply with all applicable federal and State laws and regulations, including but not limited to the following to the extent applicable to Provider in performance of the Agreement:

(a) Title VI of the Civil Rights Act of 1964; title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; Americans with Disabilities Act and section 1557 of the Patient Protection and Affordable Care Act; and their implementing regulations, as may be amended from time to time.

(b) All relevant federal and State statutes, regulations and orders related to equal opportunity in employment, including but not limited to compliance with E.O. 11246, "Equal Employment Opportunity," as amended by E.O. 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and as supplemented by regulations at 41 CFR part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor."

(c) If the Agreement is for an amount in excess of $100,000, Provider shall comply with all applicable standards, orders or regulations issued pursuant to the Clean Air Act, 42 U.S.C. 7401 et seq., and the Federal Water Pollution Control Act, as amended, 33

U.S.C. 1251 et seq. Any violations shall be reported to DHHS and the appropriate Regional Office of the Environmental Protection Agency.

3.15 **Physician Incentive Plans.** In the event Provider participates in a physician incentive plan ("PIP") under the Agreement, Provider agrees that such PIPs must comply with 42 CFR 417.479, 42 CFR 438.3, 42 CFR 422.208, and 42 CFR 422.210, as may be amended from time to time. Subcontractor, Health Plan and Provider may not make a specific payment directly or indirectly under a PIP to a physician or physician group as an inducement to reduce or limit Medically Necessary services furnished to an individual Covered Person. PIPs must not contain provisions that provide incentives, monetary or otherwise, for the withholding of services that meet the definition of Medical Necessity.

3.16 **Lobbying.** Provider agrees to comply with the following requirements related to lobbying:

(a) Prohibition on Use of Federal Funds for Lobbying: By signing the Agreement, Provider certifies to the best of Provider's knowledge and belief, pursuant to 31 U.S.C. Section 1352 and 45 CFR Part 93, as may be amended from time to time, that no federally appropriated funds have been paid or will be paid to any person by or on Provider's behalf for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

(b) Disclosure Form to Report Lobbying: If any funds other than federally appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment or modification of any federal contract, grant, loan, or cooperative agreement and the value of the Agreement exceeds $100,000, Provider shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

3.17 **Excluded Individuals and Entities.** By signing the Agreement, Provider certifies to the best of Provider's knowledge and belief that neither it nor any of its principals, nor any providers, subcontractors or consultants with whom Provider contracts and who are providing items or services that are significant and material to Provider's obligations under the Agreement is:

(a) excluded from participation in federal health care programs under either Section 1128 or section 1128A of the Social Security Act; or

(b) debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order no. 12549 or under guidelines implementing Executive Order No. 12549; or an affiliate, as defined in the Federal Acquisition Regulation, of such a person.

Provider acknowledges and agrees that payment will not be made for any items or Covered Services provided by an excluded individual pursuant to 42 CFR §1001.1901(b) and is obligated to screen all employees, contractors, and subcontractors for exclusion as required under applicable State and Federal laws. Additionally, Provider acknowledges that pursuant to 42 CFR §1003.102(a)(2) civil monetary penalties may be imposed against Provider if he or she employs or enters into contracts with excluded individuals or entities to provide items or Covered Services to Covered Persons under this Agreement. Provider agrees not to employ or subcontract with individuals or entities whose owner, those with a controlling interest, or managing employees are on a State or Federal exclusion list to provide items or Covered Services under this Agreement. Provider shall immediately report to Subcontractor and Health Plan any exclusion information discovered. Provider can search the HHS-OIG website, at no cost, by the names of any individuals or entities. The database is called LEIE and can be accessed at http://www.oig.hhs.gov/fraud/exclusions.asp. The GSA EPLS/SAM database can be accessed at https://www.sam.gov. Federal and State exclusion databases must be reviewed monthly to ensure that no employee or contractor has been excluded. Applicable state exclusion databases can be accessed through the State's Medicaid website. Subcontractor and/or Health Plan will terminate the Agreement immediately and exclude from its network any provider who has been excluded from federal health care programs or terminated from the Medicare, Medicaid or CHIP program in any state. Subcontractor and/or Health Plan may also terminate the Agreement if Provider's owners, agents, or managing employees are found to be excluded on a State or Federal exclusion list.

3.18 **Disclosure.** Provider shall cooperate with Subcontractor and Health Plan in disclosing information the Department may require related to ownership and control, significant business transactions, and persons convicted of crimes, including any required criminal background checks, in accordance with 42 C.F.R. §§ 455.104, 455.105, and 455.106. Provider shall submit information related to ownership and control of subcontractors or wholly owned suppliers within thirty-five (35) calendar days of a request for information. Additionally, Provider shall cooperate with the submission of fingerprints upon a request from the Department or CMS in accordance with 42 CFR 455.434.

3.19 **Cultural Competency and Access.** Provider shall participate in Subcontractor's, Health Plan's and the State's efforts to promote the delivery of services in a culturally competent manner to all Covered Persons, including those with limited English proficiency, physical or mental disabilities, diverse cultural and ethnic backgrounds. Provider shall provide information to Covered Persons regarding treatment options and alternatives in a manner appropriate to the Covered Person's condition and ability to understand. Provider shall provide physical access,

reasonable accommodations, and accessible equipment for Covered Persons with physical or mental disabilities.

3.20 **Marketing.** As required under State or federal law or the applicable State Contract, any marketing materials developed and distributed by Provider as related to the performance of the Agreement must be submitted to Health Plan to submit to the State Program for prior approval.

3.21 **Fraud, Waste and Abuse Prevention.** Provider shall cooperate fully with Subcontractor's and Health Plan's policies and procedures designed to protect program integrity and prevent and detect potential or suspected fraud, abuse and waste in the administration and delivery of services under the State contract and shall cooperate and assist the State Program and any other State or federal agency charged with the duty of preventing, identifying, investigating, sanctioning or prosecuting suspected fraud, abuse or waste in state and/or federal health care programs.

In accordance with Subcontractor's and Health Plan's policies and the Deficit Reduction Act of 2005 (DRA), Provider shall have written policies for its employees, contractors or agents that: (a) provide detailed information about the federal False Claims Act (established under sections 3729 through 3733 of title 31, United States Code), including, if any entity makes or receives annual payments under the State Program of at least $5,000,000, such entity must establish certain minimum written policies and information communicated through an employee handbook relating to the Federal False Claims Act in accordance with 42 CFR § 438.600; (b) cite administrative remedies for false claims and statements (established under chapter 38 of title 31, United States Code) and whistleblower protections under federal and state laws; (c) reference state laws pertaining to civil or criminal penalties for false claims and statements; and (d) with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in federal health care programs (as defined in section 1128B(f)), include as part of such written policies, detailed provisions regarding Provider's policies and procedures for detecting and preventing fraud, waste, and abuse. Provider agrees to train its staff on the aforesaid policies and procedures.

3.22 **Data; Reports.** Provider shall cooperate with and release to Subcontractor any information necessary for Subcontractor to perform its obligations under the State Contract to the extent applicable to Provider in performance of the Agreement, including the timely submission of reports and information required by Subcontractor, in the format specified by Subcontractor and the State. Such reports shall include child health check-up reporting, if applicable, as well as complete and accurate encounter data in accordance with the requirements of Subcontractor and the State. Data must be provided at the frequency and level of detail specified by Subcontractor or the State. By submitting data to Subcontractor, Provider represents and attests to Subcontractor and the State that the data is accurate, complete and truthful, and upon Subcontractor's request Subcontractor shall certify in writing, that the data is accurate, complete, and truthful, based on Provider's best knowledge, information and belief.

3.23 Encounter Data. Provider agrees to cooperate with Subcontractor to comply with Subcontractor's obligation to prepare timely encounter data submissions, reports, and clinical

information including, without limitation, child and adolescent health check-up reporting, EPSDT encounters, and cancer screening encounters, as applicable, and such other reporting regarding Covered Services as may be required under the State Contract. Encounter data must be accurate and include all services furnished to a Covered Person, including capitated provider's data and rendering provider information. Encounter data must be provided within the timeframes specified and in a form that meets Subcontractor and State requirements. By submitting encounter data to Subcontractor, Provider represents to Subcontractor that the data is accurate, complete and truthful, and upon Subcontractor's request Provider shall certify in writing, that the data is accurate, complete, and truthful, based on Provider's best knowledge, information and belief.

3.24 **Insurance Requirements.** Provider shall secure and maintain during the term of the Agreement, as applicable, general liability insurance, professional liability insurance, and workers' compensation insurance for all employees connected with the provision of services under the Agreement. Such workers compensation insurance shall comply with State Workers' Compensation Law. Such comprehensive general liability insurance and professional liability insurance shall provide coverage in an amount established by Subcontractor pursuant to the Agreement or as required under the State Contract.

3.25 **Licensure.** Provider represents that it is currently licensed and/or certified under applicable State and federal statutes and regulations and by the appropriate State licensing body or standard-setting agency, as applicable. Provider represents that it is in compliance with all applicable State and federal statutory and regulatory requirements of the Medicaid program and that it is eligible to participate in the Medicaid program. Provider represents that it does not have a Medicaid provider agreement with the Department that is terminated, suspended, denied, or not renewed as a result of any action of the Department, CMS, HHS, or the Medicaid Fraud Control Unit of the State's Attorney General. Provider shall maintain at all times throughout the term of the Agreement all necessary licenses, certifications, registrations and permits as are required to provide the health care services and/or other related activities delegated to Provider by Subcontractor under the Agreement. If at any time during the term of the Agreement, Provider is not properly licensed as described in this Section, Provider shall discontinue providing services to Covered Persons. Claims for services performed during any period of noncompliance with these license requirements will be denied.

3.26 **Clinical Laboratory Improvements Act (CLIA) certification or waiver.** As applicable, if Provider performs any laboratory tests on human specimens for the purpose of diagnosis and/or treatment, Provider agrees to acquire and maintain the appropriate CLIA certification or waiver for the type of laboratory testing performed. Provider further agrees to provide a copy of the certification if requested by Subcontractor and/or Health Plan. A State authorized license or permit that meets the CLIA requirements may be substituted for the CLIA certificate pursuant to State law. Medicare and Medicaid programs require the applicable CLIA certification or waiver for the type of services performed as a condition of payment. Provider must include the appropriate CLIA certificate or waiver number on claims submitted for payment for laboratory services.

3.27 **Quality; Utilization Management.** Pursuant to any applicable provider manuals and related protocols, or as elsewhere specified under the Agreement, Provider agrees to cooperate with Subcontractor's and Health Plan's quality assessment, performance improvement and utilization review and management activities. This shall include, but not be limited to, participation in any internal and external quality assurance, utilization review, peer review, and grievance procedures established by Subcontractor and/or Health Plan or as required under the State Contract to ensure that Covered Persons have due process for their complaints, grievances, appeals, fair hearings or requests for external review of adverse decisions made by Subcontractor, Health Plan or Provider. Provider shall adhere to the quality assurance and utilization review standards of the applicable State Program and shall monitor quality and initiate corrective action to improve quality consistent with the generally accepted level of care.

3.28 **Transition of Covered Persons.** Provider shall cooperate with Subcontractor and Health Plan in the event an immediate transfer to another primary care physician or Medicaid managed care contractor is warranted if the Covered Person's health or safety is in jeopardy, as may be required under law.

3.29 **Continuity of Care.** Provider shall cooperate with Subcontractor and Health Plan and provide a Covered Person with continuity of treatment, including coordination of care to the extent required under law, in the event Provider's participation with Subcontractor terminates during the course of a Covered Person's treatment by Provider.

In the event of Provider's insolvency or other cessation of operations, Covered Services to members shall continue through the period for which a capitation payment has been made, if any, to Subcontractor or until the Covered Person's discharge from an inpatient facility, whichever time is greater.

3.30 **Termination.** In the event of termination of the Agreement, Provider shall promptly supply to Subcontractor all information necessary for the reimbursement of any outstanding Medicaid claims.

3.31 **Prohibited Activities.** Provider shall not conduct or participate in the enrollment, disenrollment, transfer, or opt out activities of Subcontractor. Provider shall not influence a Covered Person's enrollment. Prohibited activities include:

(a) Requiring or encouraging the member to apply for an assistance category not included in MO HealthNet Managed Care;
(b) Requiring or encouraging the member and/or guardian to use the opt out provision as an option in lieu of delivering health plan benefits;
(c) Mailing or faxing health plan enrollment forms;
(d) Aiding the member in filling out health plan enrollment forms;
(e) Photocopying blank health plan enrollment forms for potential members;
(f) Distributing blank health plan enrollment forms;
(g) Participating in three way calls to the MO HealthNet Managed Care enrollment helpline;

(h) Suggesting a member transfer to another health plan; or

(i) Other activities in which subcontractors are engaged in to enroll a member in a particular health plan or in any way assisting a member to enroll in a health plan.

3.32 **Federally Qualified Health Centers**. If Provider is a federally qualified health center (FQHC) or rural health clinic (RHC) and contracted to provide services to Covered Persons under a prepayment arrangement, the Department shall reimburse the FQHC or RHC one hundred percent (100%) of its reasonable cost for covered services.

3.33 **Birth Notifications.** Providers that are hospitals must notify Subcontractor and the Family Support Division of births where the mother is a Covered Person.

3.34 **Claims.** Provider shall follow the claim processing requirements set forth by RSMo. 376.383 and 376.384, as amended.

3.35 **Consumer Protections.** Provider will comply with the consumer protection provisions outlined in the marketing guidelines in the State contract.

3.36 **National Provider Identifier (NPI).** Provider shall, 1) include his or her NPI with each claim for payment for services; 2) implement a policy of, before providing a Covered Service to a MO HealthNet adult member, requesting and inspecting the Covered Person's MO HealthNet identification card (or other documentation provided by the Department demonstrating MO HealthNet eligibility) and health plan membership card; and 3) report to Subcontractor any identified instance when the inspection discloses that the person seeking services is not a MO HealthNet Managed Care Program Covered Person.

3.37 **Off-shoring**. No Covered Services under this Agreement may be performed outside the United States.

3.38 **Attestation.** At the time of execution of this Agreement and semi-annually thereafter, Provider will provide a written attestation that Provider shall not knowingly utilize the services of an unauthorized alien to perform work under the Agreement, and shall not knowingly utilize the services of any subcontractor or other provider who will utilize the services of an unauthorized alien.

3.39 **Complaints; Appeals.** Provider shall cooperate with Subcontractor's applicable complaint, grievance and appeals processes as set forth in the provider manual(s) to ensure timely resolution and compliance with the State Contract. Provider's cooperation shall include, but is not limited to, allowing designee access to a Covered Person's medical records, Provider participation in peer reviews of a Covered Person's health care, and meeting grievance and appeal requirements of the benefit plan and the State Programs, as applicable. Provider understands and agrees that Department reserves the right and retains the authority to make reasonable inquiry and to conduct investigations into Provider and Covered Person complaints.

3.40 **Compliance with Medicaid Laws and Regulations.** Provider agrees to abide by the Medicaid laws, regulations and program instructions to the extent applicable to Provider in Provider's performance of the Agreement. Provider understands that payment of a claim by Subcontractor or the State is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited to, federal requirements on fraud, waste and abuse, disclosure, debarment, termination and exclusion screening), and is conditioned on the Provider's compliance with all applicable conditions of participation in Medicaid. Provider understands and agrees that each claim the Provider submits to Subcontractor constitutes a certification that the Provider has complied with all applicable Medicaid laws, regulations and program instructions in connection with such claims and the services provided therein. Provider's payment of a claim will be denied if Provider is terminated or excluded from participation in federal healthcare programs. Provider's payment of a claim may be temporarily suspended if the State or Subcontractor provides notice that a credible allegation of fraud exists and there is a pending investigation. Provider's payment of a claim may also be temporarily suspended or adjusted if the Provider bills a claim with a code that does not match the service provided. Subcontractor performs coding edit procedures based primarily on National Correct Coding Initiative (NCCI) policies and other nationally recognized and validated policies. Provider agrees that it will provide medical records to Subcontractor upon its request in order to determine appropriateness of coding. Provider may dispute any temporarily suspended or adjusted payment consistent with the terms of the Agreement.

3.41 **Electronic Visit Verification (EVV).** Provider shall cooperate with State requirements for electronic visit verification for personal care services and home health services, as applicable.

3.42 **Non-Discrimination.** Provider will not discriminate against Covered Persons on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability and will not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin, sex, sexual orientation, gender identity, or disability.

3.43 **Health Records.** Provider agrees to cooperate with Subcontractor to maintain and share a health record of all services provided to a Covered Person, as appropriate and in accordance with applicable laws, regulations and professional standards.

3.44 **Advance Directives.** When applicable, Provider shall comply with the advance directives requirements for hospitals, nursing facilities, providers of home and health care and personal care services, hospices, and HMOs as specified in 42 CFR Part 489, subpart I, 42 CFR § 417.436(d), 42 CFR § 422.128, and 42 CFR 438.3(i).

3.45 **Overpayment.** Provider shall to report to Subcontractor when it has received an overpayment and will return the overpayment to Subcontractor within 60 calendar days after the date on which the overpayment was identified. Provider will notify Subcontractor in writing of the reason for the overpayment.

SECTION 4
SUBCONTRACTOR AND HEALTH PLAN REQUIREMENTS

4.1 **Prompt Payment.** Subcontractor and/or Health Plan, as applicable, shall pay Provider pursuant to the State Contract and applicable State and federal law and regulations, including but not limited to 42 CFR 447.46, 42 CFR 447.45(d)(2), 42 CFR 447.45(d)(3), 42 CFR 447.45(d)(5) and 42 CFR 447.45(d)(6), as applicable and as may be amended from time to time. If a third party liability exists, payment of claims shall be determined in accordance with federal and/or State third party liability law and the terms of the State Contract. Unless Subcontractor or Health Plan otherwise requests assistance from Provider, Subcontractor or Health Plan will be responsible for third party collections in accordance with the terms of the State Contract.

4.2 **No Incentives to Limit Medically Necessary Services.** Subcontractor and Health Plan shall not structure compensation provided to individuals or entities that conduct utilization management and concurrent review activities so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary services to any Covered Person.

4.3 **Provider Discrimination Prohibition.** In accordance with 42 CFR 438.12 and 438.214(c), Subcontractor and Health Plan shall not discriminate with respect to the participation, reimbursement or indemnification of a provider who is acting within the scope of such provider's license or certification under applicable State law, solely on the basis of such license or certification. Further, Subcontractor and Health Plan shall not discriminate with respect to the participation, reimbursement or indemnification of any provider who serves high-risk Covered Persons or specializes in conditions requiring costly treatments. This provision shall not be construed as prohibiting Subcontractor and Health Plan from limiting a provider's participation to the extent necessary to meet the needs of Covered Persons. This provision also is not intended and shall not interfere with measures established by Subcontractor and Health Plan that are designed to maintain quality of care practice standards and control costs.

4.4 **Communications with Covered Persons.** Subcontractor and Health Plan shall not prohibit or otherwise restrict Provider, when acting within the lawful scope of practice, from advising or advocating on behalf of a Covered Person for the following:

(a) The Covered Person's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

(b) Any information the Covered Person needs in order to decide among all relevant treatment options;

(c) The risks, benefits, and consequences of treatment or non-treatment; or

(d) The Covered Person's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

Subcontractor and Health Plan also shall not prohibit a Provider from advocating on behalf of a Covered Person in any grievance system, utilization review process, or individual authorization process to obtain necessary health care services.

4.5 **Termination, Revocation and Sanctions.** In addition to the termination rights under the Agreement, Subcontractor and/or Health Plan shall have the right to revoke any functions or activities Subcontractor and/or Health Plan delegates to Provider under the Agreement or impose other sanctions consistent with the State Contract if in Subcontractor and/or Health Plan's reasonable judgment Provider's performance under the Agreement is inadequate. Subcontractor and Health Plan shall also have the right to suspend, deny, refuse to renew or terminate Provider in accordance with the terms of the State Contract and applicable law and regulation.

SECTION 5
OTHER REQUIREMENTS

5.1 **Compliance with State Contract.** All tasks performed under the Agreement shall be performed in accordance with the requirements of the applicable State Contract, as set forth in this Appendix, applicable provider manuals, and protocols, policies and procedures that Subcontractor and/or Health Plan has provided or delivered to Provider. The applicable provisions of the State Contract are incorporated into the Agreement by reference. Nothing in the Agreement relieves Health Plan of its responsibility under the State Contract. If any provision of the Agreement is in conflict with provisions of the State Contract, the terms of the State Contract shall control and the terms of the Agreement in conflict with those of the State Contract will be considered waived.

5.2 **Monitoring.** Subcontractor and/or Health Plan shall perform ongoing monitoring (announced or unannounced) of services rendered by Provider under the Agreement and shall perform periodic formal reviews of Provider according to a schedule established by the State, consistent with industry standards or State managed care organization laws and regulations or requirements under the State Contract. As a result of such monitoring activities, Subcontractor and/or Health Plan shall identify to Provider any deficiencies or areas for improvement mandated under the State Contract and Provider and Subcontractor and/or Health Plan shall take appropriate corrective action. Provider shall comply with any corrective action plan initiated by Subcontractor and/or Health Plan and/or required by the State Program. In addition, Provider shall monitor and report the quality of services delivered under the Agreement and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which Subcontractor, Health Plan and Provider practice and/or the performance standards established under the State Contract.

5.3 **Health Care Acquired/Preventable Conditions.** Subcontractor, Health Plan and Provider acknowledge and agree that Subcontractor and Health Plan are prohibited from making payments to Provider for the provision of medical assistance for health care-acquired conditions and other provider-preventable conditions as may be identified by the Department. As a condition of payment, Provider shall identify and report to Subcontractor any provider

preventable conditions in accordance with 42 CFR §§ 434.6(a)(12), 438, including but not limited to § 438.3(g), and § 447.26.