MississipiCHIP

REGULATORY REQUIREMENTS APPENDIX

DOWNSTREAM PROVIDER

THIS MISSISSIPPICHIP PROGRAM REGULATORY REQUIREMENTS APPENDIX (this "Appendix") supplements and is made part of the provider agreement (the "Agreement") between UnitedHealthcare of Mississippi, Inc. contracting on behalf of itself and the other entities that are its affiliates (collectively, "CCO" or "United") and the party named in the Agreement ("Provider").

SECTION 1
APPLICABILITY

This Appendix applies with respect to the provision of direct or health care related services provided by Provider under the Mississippi Children's Health Insurance Program (the "MississippiCHIP Program") as governed by the State's designated regulatory agencies. 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 CCO is required to amend or supplement this Appendix as required or requested by the State to comply with federal or State regulations, CCO will unilaterally initiate such additions, deletions or modifications. All provider agreements must be in writing and must include all specific activities and report responsibilities delegated to the Provider by CCO.

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 definition under the MississippiCHIP Program Contract, the definition shall have the meaning set forth under the MississippiCHIP Program Contract.

2.1 **Abuse:** Any practice that is inconsistent with sound fiscal, business, or medical practices, and results in an unnecessary cost to CHIP, CCO, a subcontractor, or a provider or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for healthcare.

2.2 **Adverse Benefit Determination:** The denial or limited authorization of a requested service, including determinations on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; the reduction, suspension, or termination of previously authorized services; the denial, in whole or in part, of payment for a service; CCO's failure to provide services in a timely manner; CCO's failure to resolve Complaints, Grievances, or Appeals within the specified time frames; for residents in a rural area with only one MCO, the denial of a Covered Person's request to exercise his or her right, under 42 C.F.R. §438.52(b)(2)(ii); the denial of a Covered Person's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities; and determinations by skilled nursing facilities and nursing facilities to transfer or discharge residents and adverse determinations made by a State with regard to the preadmission screening and annual resident review requirements of Section 1919(e)(7) of the Act, if applicable.

2.3 **Agreement:** An agreement between the CCO and an individual, business, university, government entity, affiliate, or nonprofit organization to perform part or all of CCO's responsibilities under the MississippiCHIP Program Contract. Agreements must be approved in writing by DOM prior to the start date of the Agreement.

2.4 **Appeal:** A request for review by CCO of an Adverse Benefit Determination related to a Member or Provider. In the case of a Member, an Adverse Benefit Determination may include determinations on the health care services a Member believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the Member). In the case of a Provider, the Adverse Benefit Determination may include, but is not limited to, delay or non-payment for covered services.

2.5 **Auto Enrollment:** The process by which Members who have not voluntarily selected a CHIP Contractor are assigned to a CHIP Contractor.

2.6 **Behavioral Health Services**: Mental health and/or substance and alcohol use disorder treatment services that are provided by the county mental health/intellectual disability/developmental disability programs, the single county authority administrators, or other appropriately licensed health care practitioners.

2.7 **Benchmark Plan:** The State School Employee's Health Insurance Plan.

2.8 **Child:** An individual who is under nineteen (19) years of age who is not eligible for Medicaid benefits and is not covered by other health insurance. Child is also referred to as Member.

2.9 **CHIP:** The Children's Health Insurance Program as defined in Title XXI of the Social Security Act.

2.10 **Complaint:** An expression of dissatisfaction received orally or in writing that is of a less serious or formal nature that is resolved within one (1) business day of receipt.

2.11 **Coordinated Care Organization (CCO):** An organization that meets the requirements for participation as a Contractor in CHIP and manages the purchase and provision of health care services under CHIP. For purposes of this Appendix, United is a CCO.

2.12 **Co-Payment:** The fixed amount certain CHIP Members pay for a covered health care service. The amount may vary based on healthcare service being provided.

2.13 **Cost Sharing:** In accordance with 42 C.F.R. §457.10, premium charges, enrollment fees, deductibles, coinsurance, Co-Payments, or other similar fees that the Member has responsibility for paying.

2.14 **Covered Services:** Health care services or products for which a Member is enrolled with CCO to receive coverage under the MississippiCHIP Program Contract, including all services required by the State Contract and State and federal law.

2.15 **Disenrollment:** Action taken by DOM, or its Agent, to remove a Member's name from the monthly Member Listing Report following DOM's receipt and approval of a request for Disenrollment or a determination that the Member is no longer eligible for Enrollment in Contractor.

2.16 **DOM:** The Division of Medicaid, Office of the Governor, State of Mississippi.

2.17 **Fraud:** Fraud is any type of intentional deception or misrepresentation made by an entity or person with the knowledge that the deception could result in some unauthorized benefit to the entity, him or herself, or some other person. The Fraud can be committed by many entities, including a vendor, a subcontractor, a

provider, a State employee, or a Member among others.

2.18 **Grievance:** An expression of dissatisfaction about any matter or aspect of CCO or its operation, other than an Adverse Benefit Determination as defined herein. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Covered Person's rights regardless of whether remedial action is requested. Grievance includes a Covered Person's right to dispute an extension of time proposed by CCO to make an authorization decision.

2.19 **Marketing:** The activities that promote visibility and awareness for the MississippiCHIP Program and the CCOs participating in the program. All marketing activities are subject to prior review and approval by DOM and may not contain misleading information.

2.20 **Medical Record:** A single complete record, which documents the entire treatment plan developed for, and medical services received by, the Member including inpatient, outpatient, referral services and emergency medical services whether provided by Contracted Providers or Non-Contracted Providers.

2.21 **Member:** An individual who meets all of the eligibility requirements for CHIP, enrolls in a CCO under CHIP, and receives health benefits coverage through CHIP.

2.22 **MississippiCHIP Program:** The Mississippi Medicaid child health program for select individuals under the age of nineteen (19) years of age who are not eligible for Medicaid benefits and are not covered by other health insurances.

2.23 **MississippiCHIP Program Contract:** The DOM contract with CCO, for the purpose of providing and paying for Covered Services to Members enrolled in the MississippiCHIP Program.

2.24 **Primary Care Provider (PCP):** Any physician or health care practitioner or group operating within the scope of his or her licensure who is responsible for supervising, prescribing and providing primary care and primary case management services in the MississippiCHIP Program, whose practice is limited to the general practice of medicine or who is an Internist, Pediatrician, Obstetrician/Gynecologist, Family and General Practitioner, Nurse Practitioners (who meet requirements of Section 4.B, Choice of a Health Care Professional), Physician Assistants, specialists who perform primary care functions upon request, and other providers approved by DOM.

2.25 **Prior Authorization:** A determination to approve a Provider's request, pursuant to services covered in the MississippiCHIP Program, to provide a service or course of treatment of a specific duration and scope to a Member prior to the initiation or continuation of the service.

2.26 **Provider Network:** The Panel of health service Providers with which the CCO contracts for the provision of covered services to Members and Non-Contracted Providers administering services to Member.

2.27 **State:** The State of Mississippi or its designated regulatory agencies.

2.28 **State Child Health Plan:** The State of Mississippi's plan submitted to HHS for the administration of CHIP.

2.29 **Third Party Liability/Resource:** Any resource available to a Member for the payment of medical expenses associated with the provision of covered services, including but not limited to, insurers and workers' compensation plan.

2.30 **Urgent Care**: Urgent care services are utilized because the Members primary care physician is not available. An urgent condition isn't life threatening but may need prompt attention. Urgent care services are for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe it requires emergency room care. Urgent care centers can typically treat things including, but not limited to, sprains, strains, minor broken bones.

2.31 **Well-Baby and Well-Child Care Services:** Regular or preventive diagnostic and treatment services necessary to ensure the health of babies, children, and adolescents as defined by DOM in the State Child Health Plan. For the purposes of Cost Sharing, the term has the meaning assigned at 42 C.F.R. § 457.520.

SECTION 3
PROVIDER REQUIREMENTS

The MississippiCHIP Program, through contractual requirements and federal and State statutes and regulations, requires that providers who provide services to Members enrolled in the MississippiCHIP Program comply with certain requirements as set forth below and elsewhere in this Appendix.

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

i) Emergency Medical Condition: In accordance with Section 1932(b) of the Act and 42 CFR §457.10, 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.

ii) Emergency Services: Covered inpatient and outpatient services, inclusive of dialysis services, furnished by a provider who is qualified to furnish those health services and that are needed to evaluate or stabilize an Emergency Medical Condition in accordance with 42 CFR 438.114.

iii) Medically Necessary Services: As set forth in the Social Security Act, Section 1905 (42 U.S.C. 1396d(a)), Medically Necessary Services are defined as services, supplies, or equipment provided by a licensed health care professional that are:

a) Appropriate and consistent with the diagnosis or treatment of the patient's condition, illness, or injury;

b) In accordance with the standards of good medical practice consistent with the individual patient's condition(s);

c) Not primarily for the personal comfort or convenience of the Member, family, or Provider;

d) The most appropriate services, supplies, equipment, or levels of care that can be safely and efficiently provided to the Member;

e) Furnished in a setting appropriate to the patient's medical need and condition and, when applied to the care of an inpatient, further mean that the Member's medical symptoms or conditions require that the services cannot be safely provided to the Member as an outpatient;

f) Not experimental or investigational or for research or education;

g) Provided by an appropriatelylicensed practitioner; and

h) Documented in the patient's record in a reasonable manner, including the relationship of the diagnosis to the service.

Medically Necessary Services may also be those services for children that are necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered during an interperiodic or Well-Baby and Well-Child Care Services, whether such services are covered or exceed the benefit limits in the Medicaid State Plan and Title 23 of Mississippi Administrative Code.

3.2 Accessibility Standards. Provider shall provide for timely access for Member appointments in accordance with the appointment availability requirements established under the MississippiCHIP Program Contract, as further described in the applicable provider manual.

Type	Appointment Scheduling Time Frames
PCP (well care visit)	Not to exceed thirty (30) calendar days
PCP (routine sick visit)	Not to exceed seven (7) calendar days
PCP (urgent care visit)	Not to exceed twenty-four (24) hours
Specialists	Not to exceed forty-five (45) calendar days
Dental Providers (routine visits)	Not to exceed forty-five (45) calendar days
Dental Providers (urgent Care)	Not to exceed forty-eight (48) hours
Behavioral Health Providers (routine visit)	Not to exceed twenty-one (21) calendar days
Behavioral Health Providers (urgent visit)	Not to exceed twenty-four (24) hours
Behavioral Health Providers (post-discharge from an acute psychiatric hospital when the Contractor is aware of the Member's discharge)	Not to exceed seven (7) calendar days
Urgent Care Providers	Not to exceed twenty-four (24) hours
Emergency Providers	Immediately (twenty-four (24) hours a day, seven (7) days a week) and without Prior Authorization

3.3 Hours of Operation; Appointments. Provider shall offer hours of operation that are no less than the hours of operation offered to commercial beneficiaries. As applicable, Provider will make Covered Services available 24 hours a day, 7 days a week when medically necessary.

3.4 PCP Responsibilities. If applicable, and Provider is a PCP, Provider shall comply with the following:

i) PCPs who serve Members under the age of nineteen (19) are responsible for conducting all Well-Baby and Well-Child Care services. Should the PCP be unable to conduct the necessary Well-Baby and Well-Child Care services screens, the PCP is responsible for arranging to have the necessary Well-Baby and Well-Child Care services screens conducted by another network provider and ensure that all relevant medical information, including the results of the Well-Baby and Well-Child Care services screens, are incorporated into the Member's PCP Medical Record.

ii) PCPs who serve Members under the age of nineteen (19) report encounter data associated with Well-Baby and Well-Child Care services, using a format approved by DOM, to Contractor within one hundred and eighty (180) calendar days from the date of service.

iii) PCPs are responsible for contacting new Members identified in the quarterly encounter lists sent by Contractor that indicate who has not had an encounter during the first six (6) months of Enrollment. Contractor must require the PCP to:

a) Contact Members identified in the quarterly Encounter lists as not complying with Well-Baby, Well-Child Care, and immunization schedules for Children;

b) Identify to Contractor any such Members who have not come into compliance with Well-Baby, Well-Child Care, and immunization schedules within one (1) month of such notification to the site by Contractor; and

c) Document the reasons for noncompliance, where possible, and to document its efforts to bring the Member's care into compliance with the standards.

iv) PCP shall provide Well-Baby and Well-Child Care Services, including vision screening, laboratory tests and hearing screenings, according to recommendations of the U.S. Preventive Services Task Force. Vision and hearing screenings shall be included as part of periodic Well-Child assessments. PCP shall have written policies and procedures related to the provision of the full-range of Well-Baby Care, Well-Child Care, and childhood and adolescent immunization services as defined in, and in accordance with, the State Child Health Plan, 42 C.F.R. §457.495, and this provisions of the MississippiCHIP Program Contract. Services shall include, without limitation, periodic health screenings and appropriate and up-to-date immunizations using the immunization schedule for all Members recommended by the Advisory Committee on Immunization Practices (ACIP). PCP shall make all reasonable efforts to identify all Members whose Medical Records do not indicate up-to-date immunizations and shall ensure that these Members receive necessary immunizations. Immunizations are purchased and distributed through the Mississippi State Department of Health. CCO shall reimburse PCP for the administration of the immunizations.

CCO requires that PCP cooperate to the maximum extent possible with the efforts to improve the health status of Mississippi citizens, and to actively work to improve the percentage of Members receiving appropriate screenings, and meet or exceed DOM's targets.

a) The following minimum elements must be included in the periodic health screening assessment of children:

i. Comprehensive health and development history (including assessment of

both physical and mental development);

ii. Measurements (e.g. head circumference for infants, height, weight, body mass index);

iii. Comprehensive unclothed physical examination;

iv. Immunizations appropriate to age and health history;

v. Assessment of nutritional status;

vi. Laboratory tests (including tuberculosis screening and Federally required blood lead screenings);

vii. Vision screening;

viii. Hearing screening;

ix. Dental and oral health assessment; and

x. Developmental and behavioral assessment.

v) If a suspected problem is detected by a screening examination, the child must be evaluated as necessary for further diagnosis. This diagnosis is used to determine treatment needs. PCP must establish a tracking system that provides information on compliance with Well-Baby and Well-Child Care services and immunization services provision requirements in the following areas:

a) Initial visit for newborns;

b) Well-Baby and Well-Child Care services and reporting of all assessment results; and

c) Diagnosis and/or treatment for Children.

vi) PCP must have an established process for reminders, follow-ups and outreach to Members that includes:

a) Written notification or upcoming or missed appointments within a set time period, taking into consideration language and literacy capabilities of Members;

b) Telephone protocols to remind Members of upcoming visits and follow-up on missed appointments within a set time period;

c) Protocols for conducting outreach with non-compliant Members, including home visits, as appropriate; and

d) A process for outreach and follow-up to Members with special health care needs.

vii) PCP may develop an alternate process for follow-up and outreach subject to prior written approval from CCO and DOM.

viii) **Specialists as PCPs**. Members with disabling conditions, chronic conditions, or with special health care needs may request that their PCP be a specialist. The designation of a specialist as a PCP must be pursuant to a treatment plan approved by Contractor; in consultation with the PCP to which the Member is currently assigned, the Member and, as appropriate, the specialist. When possible, the specialist must be a provider participating in Contractor's network. The specialist as a PCP must agree to provide or arrange for all primary care, including routine preventive care, and to provide those specialty medical services consistent with the Member's disabling condition, chronic illness, or special health care need in accordance with Contractor's standards and within the scope of the specialty training and clinical expertise. To accommodate the full spectrum of care, the specialist as a PCP must also have admitting privileges at a hospital in Contractor's network.

3.5 Provider Selection. To the extent applicable to Provider in performance under 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 re-credentialing requirements and nondiscrimination. In addition, Provider will comply with any credentialing and recredentialing requirements from the state. CCO will not require any separate credentialing and recredentialing except FFS screening.

3.6 Records Retention. As required under State or federal law or the MississippiCHIP Program Contract, Provider shall maintain a record keeping system of current, detailed, and organized records for recording services, charges, dates and all other commonly accepted information elements sufficient to disclose the quality, quantity, appropriateness and timeliness of services rendered to Members. 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 Member. Other records shall be maintained as necessary to clearly reflect all actions taken by Provider related to services provided under the MississippiCHIP Program Contract. Such records, including, as applicable, grievance and appeals records shall be maintained for a period of not less than ten (10) years from the close of the Agreement, or such other period as required by law. If records are under review or audit or are the subject of litigation they must be retained for a minimum of ten (10) years following resolution of such action. Prior approval for the disposal of records must be requested and approved by CCO if the Agreement is continuous. Provider shall have written records retention policies and procedures and will make such policies and procedures available to CCO or DOM upon request. DOM requires ready access to any and all documents and records of transactions pertaining to the provisions of services provided by Provider and those copies of requested documents/records will be provided to DOM or its designee free of charge.

3.7 Records Access. Provider agrees to cooperate with CCO 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. Provider acknowledges and agrees and shall require Provider to acknowledge and agree that DOM, 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 Members. Provider shall provide immediate access to facilities, records and supportive materials pertinent to the MississippiCHIP Program Contract for State or Federal fraud investigators.

3.8 Government Audit; Investigations. Provider acknowledges and agrees and shall require Provider to acknowledge and agree that the State or any of its duly authorized representatives, DOM, the U.S. Department of Health and Human Services, the Centers for Medicare & Medicaid Services, the Office of Inspector General, the General Accounting Office, or any other auditing agency or their authorized representatives and their designees, with prior approval by DOM, at any time during the term of the Agreement, shall, at all reasonable time and within regular business hours, with or without notice, have the

right to inspect, audit or otherwise evaluate the quality, appropriateness, and timeliness of services provided under the terms of the MississippiCHIP Program Contract and any other applicable federal and State law and regulation.

This shall include, but not be limited to, the right to enter onto Provider's premises, access to and the right to audit, inspect, monitor, and examine any pertinent books, documents, papers, medical records, financial records, surveys and computer databases and/or to otherwise evaluate the performance of Provider related to Provider's performance under the Agreement. Such monitoring activities may also include, without limitation, on-site inspections of all service locations and facilities; auditing and/or review of all records developed under the MississippiCHIP Program Contract or the Agreement; reviewing management systems and procedures developed under the MississippiCHIP Program Contract or the Agreement; and review of any other areas of materials relevant or pertaining to the MississippiCHIP Program Contract or the Agreement. All reviews and audits shall be performed in such a manner as will not unduly delay the work of Provider. There will be no restrictions on the right of the State or federal authorities to conduct inspections and audits as necessary.

The Provider must fully cooperate with any and all reviews and/or audits by state or federal agencies, such as the Department of Audit, Department of Health and Human Services, Centers for Medicare and Medicaid Services, Office of Inspector General, General Accounting Office, or any other auditing agency approved by DOM, by assuring that appropriate employees and involved parties are available for interviews relating to the reviews or audits.

All records shall be maintained and available for review by authorized federal and state agencies during the entire term of the MississippiCHIP Program Contract and for a period of ten (10) years thereafter, unless an audit, litigation, or other legal action is in progress. When an audit or litigation is in progress or audit findings are unresolved, records shall be kept for a period of ten (10) years or until all issues are finally resolved, whichever is later. The Provider must have written policies and procedures for storing this information. Records must be kept in an original paper state or preserved on micro media or electronic format.

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

Provider shall be able to receive, maintain and utilize applicable data extracts from CCO or DOM and systematically update its database within five (5) calendar days of receipt of the files. Data extract files include but are not limited to the following, as applicable: 1. Daily Active Provider Extract; 2. Weekly Provider Affiliation Details Extract; 3. 834 Enrollment Files; 4. 835 Claims Payment Remittance Advice Transaction; 5. 277 Claims Acknowledgement; 6. NCPDP Formulary; 7. NCPDP Response File; 8. TPL Resource/Policy Information File, etc.; 9. Claims History Extracts; and 10. Prior Authorization Extracts.

3.10 Encounter Data. Provider shall agree to cooperate with CCO to comply with CCO's obligation to prepare encounter data submissions, reports, and clinical information including, without limitation, and well-baby/well-child reporting and encounters, as applicable, and such other reporting regarding Covered

Services as may be required under the MississippiCHIP Program 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 CCO and State requirements. By submitting encounter data to CCO, Provider represents to CCO that the data is accurate, complete and truthful, and upon CCO's request Provider shall certify in writing, that the data is accurate, complete, and truthful, based on Provider's best knowledge, information and belief.

3.11 Claims Information. Provider shall promptly submit to CCO the information needed to make payment and shall identify third party liability coverage, including Medicare and other insurance, and if applicable seek such third party liability payment before submitting claims to CCO. Provider understands and agrees that each claim Provider submits to CCO constitutes a certification that the claim is true and accurate to the best of Provider's knowledge and belief and that the Covered Services are 1) Medically Necessary and 2) have been provided to the Member prior to submitting the claim.

Provider must submit claims within six (6) months from the date of service. Claims filed within the appropriate time frame but denied may be resubmitted to CCO within ninety (90) calendar days from the date of denial.

3.12 Third Party Resources. Provider shall report all Third Party Resources to CCO identified through the provision of medical services.

3.13 Privacy; HIPAA. Provider shall comply with all applicable privacy rule and security rule provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and associated implementing regulations, as may be amended from time to time, and shall safeguard information about Members in accordance with applicable federal and State privacy laws and rules including 42 CFR §438.224 and 42 CFR Part 431, Subpart F, as may be amended from time to time. Provider agrees that confidential information, including but not limited to, medical and other pertinent information relative to Members, shall not be disclosed to any person or organization for any purpose without the expressed, written authority of DOM or as otherwise required by law and that all such disclosures shall fully comply with HIPAA privacy and security standards.

3.14 Cultural Competency and Access. Provider shall participate in CCO's and DOM's efforts to promote the delivery of services in a culturally competent manner to all Members, including those with limited English proficiency, physical or mental disabilities, diverse cultural and ethnic backgrounds and regardless of gender, sexual orientation or gender identity, and shall provide interpreter services in a Member's primary language and for the hearing impaired for all appointments and emergency services. Provider shall provide information to Members regarding treatment options and alternatives, as well as information on complaints and appeals, in a manner appropriate to the Member's condition and ability to understand. Provider shall provide physical access, reasonable accommodations, and accessible equipment for Covered Persons with physical or mental disabilities.

3.15 Approval of Marketing Materials. As required under State or federal law or the applicable MississippiCHIP Program Contract, any marketing materials developed and distributed by Provider as related to the performance of the Agreement must be submitted to CCO at least sixty (60) days prior to planned distribution for timely submission to DOM for prior approval. Provider agrees it will not proceed with the statement or communication until the required approval is obtained.

3.16 Independent Contractor Relationship. Provider expressly agrees that Provider is acting in an independent capacity in the performance of the Agreement and not as an officer, agent or employee of DOM, CMS or the

State. Provider further expressly agrees that the Agreement shall not be construed as a partnership or joint venture between Provider and DOM, CMS or the State. Nothing in the Agreement shall be construed, nor shall it be deemed to create, any right or remedy in any third party.

3.17 Certification on Relationship to State, DOM and CMS. Provider certifies that no officer, director, employee, subcontractor or agent of Provider, or person with an ownership or control interest in Provider, is also employed by, or is a public official of, the State of Mississippi or any of its agencies, DOM or CMS.

3.18 Ownership and Control Information. If applicable, Provider shall cooperate with CCO in obtaining and providing information to DOM related to ownership and control, significant business transactions, and persons convicted of a criminal offense in compliance with§1128 of the Social Security Act, 42 USC §1320a-7 and 42 CFR Part 455, as amended and shall provide information upon request. Provider shall submit information related to ownership and control of subcontractors or wholly owned supplier within thirty-five (35) calendar days of a request for such information.

By executing the Agreement, Provider certifies that neither Provider nor any of its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in any State or federal health care program or from participating in transactions by any State or federal department or agency. CCO will terminate the Agreement upon becoming aware or receiving notice from DOM, whichever is earlier, that Provider is or has been excluded from participation in any State or federal health care program or by any State or federal agency.

3.19 Excluded Individuals and Entities. Provider certifies that neither it nor any of its employees, principals, nor any providers, subcontractors or consultants or persons with an ownership or controlling interest in the Provider (an owner including the Provider himself or herself), or an agent or managing employee of the Provider, with whom Provider contracts and who are providing items or services that are significant and material to Provider's obligations under the Agreement is:

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

ii) debarred, suspended, proposed for debarment, declared ineligible, or otherwise voluntarily excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement 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 and shall require that Provider acknowledge and agree 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 Member under the 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 the Agreement. Provider shall immediately report to CCO 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. CCO will terminate the Agreement immediately upon becoming aware or receiving notice from DOM, whichever is earlier, that Provider's owners, agents, managing employees, or any provider is or has been excluded from federal health care programs or terminated from the Medicare or the Medicaid program in any state.

3.20 **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 does not have a Medicaid provider agreement with DOM that is terminated, suspended, denied, or not renewed as a result of any action of DOM, 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 CCO 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 Members.

3.21 **National Provider ID (NPI).** If applicable, Provider shall and shall require that Providers obtain a National Provider Identification Number (NPI) and when filing claims with Provider, the NPI number used is the same NPI number used when filing claims with DOM.

3.22 **Funding.** Provider recognizes that the obligation of DOM to proceed under its MississippiCHIP Program Contract with CCO is conditioned upon the appropriation of funds by the Mississippi State Legislature and the receipt of State and/or Federal funds. If the funds anticipated for the continuing fulfillment of the agreement are, at any time, not forthcoming or insufficient, either through the failure of the Federal government to provide or the State of Mississippi to appropriate funds, or the discontinuance, or material alteration of the program under which the funds were provided or if funds are not otherwise available to DOM, DOM has the right upon ten (10) working days written notice to CCO to terminate the MississippiCHIP Program Contract.

3.23 **Federal and State Funds Liability.** Providers acknowledges and agrees that payments made to Provider for services provided under the Agreement are derived from federal and State funds and that any false claim or statement in documents or any concealment of material fact related to such services may be a cause for sanctions and prosecution under applicable federal and State laws. Provider shall be subject to all laws applicable to individuals and entities receiving State and federal funds and may be held civilly or criminally liable to both CCO and DOM in the event of nonperformance, misrepresentation, fraud, or abuse related to services provided pursuant to the MississippiCHIP Program Contract. Provider recognizes that payments made to the Provider are derived from federal and State funds, and are contingent upon and subject to availability and receipt of funds.

3.24 **Insolvency**. In the event CCO becomes insolvent or unable to pay Provider, Provider shall not seek compensation for services rendered from DOM, its officers, Agents, or employees, or the Members or their eligible dependents.

3.25 **Termination.** In the event of termination of the Agreement, Provider shall promptly supply to CCO all information necessary for the reimbursement of any outstanding MississippiCHIP Program claims.

3.26 **Capitated Providers.** If a Provider that is capitated terminates its agreement with CCO, for any reason, Provider will provide services to Members assigned to Provider up to the end of the month in which the effective date of termination falls.

3.27 Fraud, Waste, and Abuse Prevention. Provider shall cooperate fully with the CCO's policies and procedures designed to protect program integrity and prevent and detect potential or suspected fraud, waste, and abuse in the administration and delivery of services under the MississippiCHIP Program Contract and shall cooperate and assist DOM and any other State or federal agency charged with the duty of preventing, identifying, investigating, sanctioning or prosecuting suspected fraud, waste, and abuse in state and/or federal health care programs. Provider and CCO are responsible for reporting suspected fraud and abuse by participating and non-participating providers, as well as Members, when detected.

In accordance with CCO'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.

3.28 Quality Utilization Management. Pursuant to any applicable provider manuals and related protocols, or as elsewhere specified under the Agreement, Provider agrees to cooperate with CCO's quality 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 CCO or as required under the MississippiCHIP Program Contract to ensure that Members have due process for their complaints, grievances, appeals, fair hearings or requests for external review of adverse decisions made by CCO or Provider. Provider shall adhere to the quality assurance and utilization review standards of the MississippiCHIP Program and shall monitor quality and initiate corrective action to improve quality consistent with the generally accepted level of care.

3.29 Quality and Utilization Management Program. Provider shall cooperate with CCO in meeting the Quality Management and Utilization Management Program standards outlined in the MississippiCHIP Program Contract.

3.30 Referrals. Provider shall make referrals for social, vocational, education or human services when a need for such service is identified.

3.31 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.

3.32 Complaints, Grievances and Appeals. Information on how Provider or Provider's authorized representative shall submit complaints and file grievances and appeals, and the resolution process, is contained in the CCO MississippiCHIP Provider Manual.

3.33 Health Care Acquired/Preventable Conditions. Provider agrees that no payment shall be made for the provision of medical assistance for health care acquired conditions and other provider preventable conditions as may be identified by the State. As a condition of payment, Provider shall identify and report

to CCO 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.

3.34 Compliance with Laws. Provider shall comply with all applicable federal and State laws and regulations and all provisions of the MississippiCHIP Program Contract that pertain to a Member's rights, including but not limited to the following, to the extent applicable to Provider in performance of the Agreement:

i) Title VI of the Civil Rights Act of 1964; (b) Title XIX of the Social Security Act; Title IX of the Education Amendments of1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; and The Genetic Information Non-Discrimination Act of 2008 (GINA); the Americans with Disabilities Act; section 1557 of the Patient Protection and Affordable Care Act, and their implementing regulations, as may be amended from time to time.

ii) All federal and State professional and facility licensing and accreditation requirements/standards that apply to the services Provider perform pursuant to the Agreement, including but not limited to:

a) All applicable standards, orders or requirements issued under Section 306 of the Clean Air Act (42 USC 1857 (h)). Section 508 of the Clean Water Act (33 USC 1368), Executive Order 11738, and Environmental Protection Agency (EPA) regulations (40) CFR Part 15), which prohibit the use of facilities included on the EPA list of violating facilities. Any violations must be reported to DSHS, DHHS, and the EPA;

b) Any applicable mandatory standards and policies relating to energy efficiency that are contained in the State Energy Conservation Plan, including the Energy Policy & conservation Act (Pub. L. 94-165), and issued in compliance with the Federal Energy Policy & Conservation Act.

iii) 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."

iv) 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.

v) Those specified for laboratory services in the Clinical Laboratory Improvement Amendments (CLIA). All laboratory service sites must have a CLIA certificate of registration or waiver, and a CLIA identification number.

vi) The American with Disabilities Act (ADA). Provider shall make reasonable accommodation for Members with disabilities in accord with the ADA for all Covered Services and shall assure physical and communication barriers do not inhibit Members with disabilities from obtaining Covered Services;

vii) Section 1128B(d)(1) of the Balanced Budget Act of 1997; and,

viii) Any other requirements associated with the receipt of federal funds.

ix) All 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 CCO 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 CCO 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 CCO 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. CCO 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 CCO 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.

3.35 Non-Discrimination. Provider will not discriminate against, nor use any policy or practice that has the effect of discriminating against, Covered Persons on the basis of race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual orientation, gender identity, language, health status, disease or pre-existing condition (including genetic information), anticipated need for health care or physical or mental handicap, except where medically indicated. Examples of prohibited practices include, but are not limited to, the following:

i) Denying or not providing a Member any MississippiCHIP Covered Service. Health care and treatment necessary to preserve life must be provided to all Members who are not terminally ill or permanently unconscious, except where a competent Member objects to such care on his/her own behalf.

ii) Subjecting a Member to segregated, separate, or different treatment, including a different place or time from that provided to other Members or public or private patients, in any manner related to the receipt of any MississippiCHIP Covered Service, except where Medically Necessary.

iii) The assignment of times or places for the provision of services on the basis of the race, color, creed, religion, age, sex, national origin, ancestry, marital status, sexual orientation, gender identity, income status, program membership, language, health status, disease or pre-existing condition, anticipated need for health care or physical or mental disability of the Members to be served.

3.36 Advance Directives. Provider shall comply with the advance directives requirements with 42 C.F.R §422.128 and with the Uniform Health-Care Decisions Act (Miss. Code Ann. § 41-41-201, *et. seq*.). 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 49, subpart I, 42 CFR § 417.436(d), 42 CFR § 422.128, and 42 CFR 438.3(i).

3.37 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. CCO or 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 Member. PIPs must not contain provisions that provide incentives, monetary or otherwise, for the withholding of services that meet the definition of Medical Necessity. Provider shall disclose annually to CCO any PIP arrangement Provider may have with any physicians even if there is not substantial financial risk between CCO and such physicians.

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

i) 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. § 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.

ii) 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.

iii) Contractor shall abide by lobbying laws of the State of Mississippi.

3.39 Gratuities. Provider represents that it has not violated, is not violating, and promises that it will not violate the prohibitions against gratuities set forth in Section 6-204 (Gratuities) of the Mississippi Personal Service Contract Procurement Regulations.

3.40 Compliance with Mississippi Employment Protection Act (MEPA). Represents and warrants and shall require that Provider represent and warrant that it will ensure its compliance with the Mississippi Employment Protection Act, Section 71-11-1 et set of the Mississippi Code Annotated (Supp. 2008), and will register and participate in the status verification system for all newly hired employees. The term "employee" as used herein means any person that is hired to perform work within the State of Mississippi. As used herein, "status verification system" means the Illegal Immigration Reform and Immigration Responsibility Act of 1996 that is operated by the United States Department of Homeland Security, also known as the E-Verify Program, or any other successor electronic verification system replacing the E-Verify Program. Provider agrees and shall require that Provider agree to maintain records of such compliance and, upon request of the State and approval of the Social Security Administration or Department of Homeland Security, where required, to provide a copy of each such verification to the State. Provider represents and warrants that any person assigned to perform services hereunder meets the employment eligibility requirements of all immigration laws of the State of Mississippi. Provider acknowledges and agrees that

any breach of these warranties may subject Provider to the following: (a) termination of the Agreement and ineligibility for any state or public contract in Mississippi for up to three (3) years, with notice of such cancellation/termination being made public, or (b) the loss of any license, permit, certification or other document granted to Provider by an agency, department or governmental entity for the right to do business in Mississippi for up to one (1) year, or (c) both.

3.41 Insurance Requirements. As applicable, Provider shall and shall require that Provider secure and maintain during the term of the Agreement 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 Mississippi Workers' Compensation Laws. Such comprehensive general liability insurance and professional liability insurance shall provide coverage in an amount established by CCO pursuant to the Agreement or as required under the MississippiCHIP Program Contract.

3.42 Indemnification. To the extent applicable to Provider in performance under the Agreement, Provider shall indemnify, defend, protect, save and hold DOM and its employees and Members harmless from and against all injuries, deaths, losses, damages, claims, suits, demands, actions, recovery, liabilities, judgments, costs and expenses, including without limitation, court costs, investigative fees and expenses, and attorney fees, to the extent proximately caused by any negligent act or other intentional misconduct or omission of Provider, its agents, officers, employees or contractors arising from the Agreement. DOM may waive this requirement 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. This clause shall survive the termination of the Agreement for any reason, including breach due to insolvency.

3.43 Notice of Legal Action. Immediately upon obtaining knowledge or receiving notice of any legal action or notice listed below, Provider shall provide to CCO written notice of such legal action or notice and, upon request by CCO, a complete copy of all filings and other documents generated in connection with any such legal action:

i) Any action, suit or counterclaim filed against Provider;

ii) Any regulatory action, or proposed action, respecting Provider's business or operations;

iii) Any notice received by Provider from the Department of Insurance or the State Health Officer;

iv) The filing of a petition in bankruptcy by or against Provider, or the insolvency of Provider;

v) The conviction of any person who has an ownership or control interest in Provider, or who is an agent or managing employee of Provider, of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or Title XX of the Social Security Act; or

vi) A malpractice action against any Provider delivering service under an agreement.

3.44 Hold Harmless. Except for any applicable cost-sharing requirements under the MississippiCHIP Program Contract, Provider shall look solely to CCO for payment of Covered Services provided to Members pursuant to the Agreement and the MississippiCHIP Program Contract and hold DOM, the State, the U.S. Department of Health and Human Services and Members harmless in the event that CCO cannot or will not pay for such Covered Services. In accordance with 42 CFR § 447.15, as may be amended from time to time, the Member is not liable to Provider for any services for which CCO 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 MississippiCHIP Program Contract. Provider shall also be prohibited from charging Members for missed appointments if such practice is prohibited under the MississippiCHIP Program Contract or applicable law. Neither the State, DOM, nor Member shall be in any manner liable for the debts and obligations of CCO and under no circumstances shall CCO, or any providers used to deliver services covered under the terms of the MississippiCHIP Program Contract, charge Members for Covered Services.

3.45 Assignment/Delegation. Provider shall not assign or delegate the Agreement without the express written consent of CCO or DOM. If Provider subcontracts or delegates any functions of the Agreement, in accordance with the terms of the Agreement and with the express written consent of CCO or DOM, the subcontract or delegation must be in writing and include all of the requirements of this Appendix, and applicable requirements of the State Contract, and applicable laws and regulations. The transfer of five percent (5%) or more of the beneficial ownership in Provider at any time during the term of this Agreement shall be deemed an assignment under this Agreement.

3.46 Behavioral Health Providers. Behavioral Health Providers shall ensure that all Covered Persons receiving inpatient psychiatric services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge from the inpatient psychiatric hospital if the Provider is aware of the Covered Person's inpatient hospitalization status. Behavioral Health Providers will be provided daily reports identifying Covered Persons known to be admitted to an inpatient facility. Behavioral Health Services will be delivered in compliance with the requirements of 42 CFR 438 subpart K insofar as those requirements are applicable.

3.47 Provider Eligibility. Provider must be enrolled in the Mississippi CHIP program and must use the same National Provider Identifier (NPI) number to participate in CCO's Network. Upon notification from the State that Provider's enrollment has been denied or terminated, CCO must terminate Provider immediately and will notify affected Covered Persons that Provider is no longer participating in the network. CCO will exclude from its network any provider who has been terminated or suspended from the Medicare, Medicaid or CHIP program in any state.

3.48 Disclosure. Provider must be screened and enrolled in the State's CHIP program and submit disclosures to the DOM related to ownership and control, significant business transactions, and persons convicted of crimes in accordance with 42 CFR Part 455 .Provider must submit information related to ownership and control of subcontractors or wholly owned suppliers within thirty-five (35) calendar days of a request for such information in accordance with 42 CFR 455.105. Additionally, Provider must cooperate with DOM for submission of fingerprints upon a request from DOM or CMS in accordance with 42 CFR 455.434.

3.49 Electronic Visit Verification. Provider shall cooperate with State requirements for electronic visit verification for personal care services and home health services, as applicable.

3.50 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 CCO. 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.

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

SECTION 4
CCO REQUIREMENTS

4.1 Communications with Members. Members are entitled to the full range of their Providers' opinions and counsel about the availability of Medically Necessary Services under the provisions of the MississippiCHIP Program Contract. Any contractual provisions, including gag clauses or rules, that restrict a Provider's ability to advise Members about Medically Necessary treatment options violate federal law and regulations. CCO shall not prohibit or otherwise restrict Provider, when acting within the lawful scope of practice, from advising or advocating on behalf of a Member for the following:

i) The Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

ii) Any information the Member needs in order to decide among all relevant treatment options;

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

iv) The Member'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; or

v) Information regarding the nature of treatment options including those that may not reflect CCO's position or may not be covered by CCO.

CCO shall not prohibit a Provider from advocating on behalf of a Member in any grievance system, utilization review process, or individual authorization process to obtain necessary health care services.

4.2 Prompt Payment. CCO shall pay Provider pursuant to the MississippiCHIP Program Contract and applicable State and federal law and regulations, including but not limited to Miss. Code Ann. §83-9-5, 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 MississippiCHIP Program Contract. Unless CCO otherwise requests assistance from Provider, CCO will be responsible for third party collections in accordance with the terms of the MississippiCHIP Program Contract.

4.3 No Incentives to Limit Medically Necessary Services. CCO 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 Member.

4.4 Provider Discrimination Prohibition. CCO shall not discriminate with respect to participation, reimbursement, or indemnification of a provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification. CCO shall not discriminate against Provider for serving high-risk Members or if Provider specializes in conditions

requiring costly treatments. This provision shall not be construed as prohibiting CCO from limiting a provider's participation to the extent necessary to meet the needs of Members. This provision also is not intended and shall not interfere with measures established by CCO that are designed to maintain quality of care practice standards and control costs. CCO shall not provide false or misleading information to any person or entity in an attempt to recruit Providers for CCO's network.

4.5 Termination, Revocation and Sanctions. In addition to its termination rights under the Agreement, CCO shall have the right to revoke any functions or activities CCO delegates to Provider under the Agreement or impose other sanctions consistent with the MississippiCHIP Program Contract if in CCO's reasonable judgment Provider's performance under the Agreement is inadequate. CCO shall also have the right to suspend, deny, refuse to renew or terminate the subcontract in accordance with the terms of the MississippiCHIP Program Contract and applicable law and regulation. However, CCO shall not exclude or terminate a Provider from participation in CCO's Provider Network due to the fact that the Provider has a practice that includes a substantial number of patients with expensive medical conditions, and shall not terminate a Provider for filing a Complaint, Grievance, or Appeal on a Member's behalf.

SECTION 5
OTHER REQUIREMENTS

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

5.2 Monitoring. In accordance with 42CFR § 457.950, CCO 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 MississippiCHIP Program Contract. As a result of such monitoring activities, and/or as a result of the inspecting, auditing and monitoring activities of DOM or other authorities pursuant to section 4.4 above, CCO shall identify to Provider any deficiencies or areas for improvement mandated under the MississippiCHIP Program Contract and Provider and CCO shall take appropriate corrective action within the relevant timeframe permitted, as applicable. Provider shall comply with any corrective action plan initiated by CCO and/or required by the MississippiCHIP 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 CCO and Provider practice and/or the performance standards established under the MississippiCHIP Program Contract.

5.3 Enrollment. The parties acknowledge and agree that DOM is responsible for enrollment, reenrollment and disenrollment of Members.

5.4 No Exclusivity. Nothing in the Agreement or this Appendix shall be construed as prohibiting or penalizing Provider for contracting with a managed care organization other than CCO or as prohibiting or penalizing CCO for contracting with other providers. The CCO may not require Providers who agree to participate in

the MississippiCHIP Program to contract with the Contractor's other lines of business.

5.5 Revoking Delegation. The parties agree that, prior to execution of the Agreement, CCO evaluated Provider's ability to perform any duties delegated to Provider under the Agreement. Any delegated duties and reporting responsibilities shall be set forth in the Agreement or other written delegation agreement or addendum between the parties. In addition to its termination rights under the Agreement, CCO shall have the right to revoke any functions, assignment authority, or activities CCO delegates to Provider under the Agreement or impose other sanctions if in CCO's reasonable judgment Provider's performance under the Agreement is inadequate or untimely.

5.6 Rights of DOM. DOM shall have the right to invoke against Provider any remedy set forth in the MississippiCHIP Program Contract, including the right to require the termination of the Agreement, for each and every reason for which it may invoke such a remedy against CCO or require termination of the MississippiCHIP Program Contract. Suspected Fraud and Abuse by Provider will be investigated by DOM.