NEW MEXICO MEDICAID AND CHIP REGULATORY REQUIREMENTS APPENDIX

DOWNSTREAM PROVIDER

THIS New Mexico MEDICAID AND CHIP REGULATORY REQUIREMENTS APPENDIX (this "Appendix") supplements and is made part of the provider agreement (the "Agreement") between UnitedHealthcare Insurance Company or one of its Affiliates and the party named in the Agreement ("Provider").

SECTION 1 APPLICABILITY

This Appendix applies to benefit plans sponsored, issued or administered by UnitedHealthcare Insurance Company or one of its Affiliates (referred to in this Appendix as "United") under the State's Medicaid program, CHIP program and, as applicable, benefit plans for other state-based healthcare programs (the "State 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.

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 Covered Service means health care service or product for which a Member is enrolled with United to receive coverage under the State Contract.

2.2 HCA: New Mexico Health Care Authority.

2.3 Medicaid Agency or Agency means the single State agency administering or supervising the administration of a State Program.

2.4 State: The State of New Mexico.

2.5 State Contract is the contract between United and the Medicaid Agency for the purpose of providing and paying for Covered Services to Members enrolled in the State Program. The contract is titled the New Mexico Medicaid Managed Care Services Agreement and can be located at www.hsd.state.nm by searching Turquoise Care MCOs Contracts.

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 United 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 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** means 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: (a) 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; (b) serious impairment to body functions; or (c) serious dysfunction of any body organ or part.

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

iii) **Medically Necessary or Medical Necessity** has the same meaning as contained in 42 C.F.R. § 438.210(a)(5) and as indicated in State statutes and regulations, the State Contract, and other State policy and procedures.

iv) **Poststabilization Care Services** means covered services, related to an emergency medical condition that are provided after an enrollee is stabilized to maintain the stabilized condition, or, under circumstances described in condition that are provided after an enrollee is stabilized to maintain the stabilized condition, or, under the circumstances described in 42 C.F.R. § 422.113(c), to improve or resolve the enrollee's condition.

3.2 Provider Participation Requirements. Provider hereby acknowledges and certifies to the best of its knowledge the following:

i) State Program Participation. Provider is enrolled as, or has applied to enroll as, a participating provider with the New Mexico Medicaid Program. United may terminate Provider from its New Mexico Medicaid Benefit Plans network immediately upon notification from the State that Provider cannot be enrolled or has been terminated from the State Program, or the expiration of one 120 day period without enrollment of Provider. If Provider is located in the State of New Mexico, Provider has a legal basis to operate in the State.

ii) Licensure. Provider has 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 United under the Agreement and will maintain such necessary licenses,

certifications, registrations and permits at all times throughout the term of the Agreement. If at any time during the term of the Agreement, Provider is not in compliance with this Section, Provider shall discontinue providing services to Members. Additionally, payment will not be made for any items or Covered Services provided during any time period of noncompliance with this Section.

iii) Excluded Individuals and Entities. Provider nor any of its employees, principals, nor any providers, subcontractors or consultants or persons with an ownership or controlling interest in the Provider are: (a) 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 b) excluded from participation in federal health care programs under either 42 U.S.C. §§ 1320a–7 or 1320a–7a. Provider acknowledges and agrees that payment will not be made for any items or Covered Services provided by an excluded individual or entity pursuant to 42 C.F.R. § 1001.1901(b).

3.3 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:

i) **Civil Rights.** Provider shall comply with Title VI of the Civil Rights Act of 1964; the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; Title IX of the Education Amendments of 1972; Titles II and III of the Americans with Disabilities Act; and section 1557 of the Patient Protection and Affordable Care Act (see 42 CFR 438.3; 42 CFR 438.100(d)).

ii) **Lobbying.** Provider certifies to the best of Provider's knowledge and belief, pursuant to 31 U.S.C. § 1352 and 45 C.F.R. § 93.100 et seq. 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.

iii) **Medicaid Laws and Regulations.** Provider agrees to abide by all federal and state Medicaid laws, regulations and State Program requirements to the extent applicable to Provider in Provider's performance of the Agreement, including but not limited to:

a. 5 C.F.R. § 900.601 et seq., Administration of the Standards for a Merit System of Personnel Administration.

b. The following HHS Regulations in 45 C.F.R. subtitle A:

i. 45 C.F.R. § 16.1 et seq., Procedures of the Departmental Appeals Board;

ii. 45 C.F.R. § 75.1 et seq., Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards;

iii. 45 C.F.R. § 80.1 et seq., Nondiscrimination Under Programs Receiving Federal Assistance Through the Department of Health and Human Services: Effectuation of Title VI of the Civil Rights Act of 1964;

iv. 45 C.F.R. § 81.1 et seq., Practice and Procedure for Hearings Under 45 C.F.R. § 80.1 et seq.;

v. 45 C.F.R. § 84.1 et seq., Nondiscrimination on the Basis of Handicap in Programs and Activities Receiving or Benefiting from Federal Financial Assistance.

c. **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 C.F.R. §§ 417.436(d), 422.128, and 438.3(i).

d. **Availability of Services.** Provider will comply with 42 C.F.R. § 438.206 and the Provider Manual regarding availability of services to Members including, but not limited to, meeting State Program standards for timely access to care and services, taking into account the urgency of the need for services. Additionally, 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 beneficiaries, 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. In addition, Provider will provide physical access, reasonable accommodations and accessible equipment for Members with physical or mental disabilities.

e. **Claims Information.** Provider shall promptly submit to United 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 United.

f. **Continuity of Care.** Provider shall cooperate with United and provide Members with continuity of treatment, including coordination of care to the extent required under law and according to the terms of the Agreement, in the event Provider's participation with United terminates during the course of a Member's treatment by Provider, except in the case of adverse reasons on the part of Provider.

g. **Cultural Competency and Access.** Provider shall participate in United's and the State's efforts to efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of sex, 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 Members with physical or mental disabilities.

h. **Data; Reports.** Provider agrees to cooperate with and release to United any information necessary for United to comply with the State Contract and federal and state law, to the extent applicable to Provider in performance of the Agreement. Such information includes timely submission of reports including child health check-up reporting, EPSDT encounters, and cancer screening encounters, if applicable, as well as complete and accurate encounter data in accordance with the requirements of United and the State. By submitting data to United, Provider represents and attests to United and the State that the data is accurate, complete and truthful, and upon United's request Provider shall certify in writing, that the data is accurate, complete, and truthful, based on Provider's best knowledge, information and belief.

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

j. **Fraud, Waste, and Abuse.** Provider understands and agrees that each claim the Provider submits to United 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 United 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. United 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 United upon its request in order to determine appropriateness of coding. Further, when Provider t has received an overpayment, Provider will return the overpayment to United within 60 calendar days after the date on which the overpayment was identified, and to notify United in writing of the reason for the overpayment.

k. **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 or documents of Provider and its subcontractors, and the right to

inspect the premises, physical facilities, and 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. United shall monitor Provider's performance on an ongoing basis and subject the Provider to formal periodic review. As part of this review, United may conduct unannounced, in-person site visits, audits, or other reviews to ensure services are being rendered and billed correctly.

l. **Hold Harmless.** Provider will accept, as payment in full, the amounts paid by United to Provider for Covered Services to Members, plus any deductible, coinsurance or copayment required to be paid by the Member, and will hold Members and HCA harmless in the event that United cannot or will not pay for such Covered Services. If a service is not a Covered Services, prior to providing the service, Provider shall inform the Member the service is not a Covered Service and have the Member acknowledge the information. If the Member still requests the service, Provider shall obtain such acknowledgement in writing, on an HCA-approved form provided by United, prior to rendering the service. If United determines a Member was charged for Covered Services inappropriately, such payment may be recovered, as applicable. This provision shall survive any termination of the Agreement, including breach of the Agreement due to insolvency.

m. **Marketing.** Provider will comply with 42 C.F.R. § 438.104 and any applicable State Program guidance and regulations related to marketing materials including, but not limited to, seeking approval from the Medicaid Agency prior to distributing any marketing materials to Members.

n. **Physician Incentive Plans.** If Provider participates in a physician incentive program ("PIP"), Provider must comply with the requirements set forth in 42 C.F.R. §§ 422.208 and 422.210, including but not limited to the following: a) Provider will not make specific payment, directly or indirectly, to a physician or physician group as an inducement to reduce or limit Medically Necessary services furnished to any Member; and b) if the PIP places Provider at substantial financial risk for services that Provider does not furnish itself, Provider must have stop-loss protection in accordance with 42 C.F.R. § 422.208(f).

o. **Preventable Conditions.** No payment will be made by United to a Provider for provider preventable conditions, as identified in the State Program. Provider shall identify and report to United any provider preventable conditions in accordance with 42 C.F.R. §§ 434.6(a)(12)(i) and (ii) and 42 C.F.R. § 447.26(d).

p. **Privacy; Confidentiality.** Provider understands that the use and disclosure of information concerning Members is restricted to purposes directly connected with the administration of the State Program and shall maintain the confidentiality of

Member'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 Members 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 438.3 (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 United and the Department of any breach of confidential information related to Members 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 United 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 United and the Department to ensure that the breach has been mitigated and reporting requirements, if any, complied with.

q. **Quality; Utilization Management.** Provider agrees to cooperate with United'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, appeal procedures and grievance procedures established by United or as required under the State 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 United or Provider. To receive payment, Provider must comply with Section 4.17 of the HCA

Contract regarding the Grievances and Appeal System. Provider shall adhere to the quality assurance and utilization review standards of the State Program and shall monitor quality and corrective action initiated by United to improve quality in accordance with that level of medical, Behavioral Health or LTC that is recognized as acceptable professional practices and/or the standards established by HCA.

r. **Records.** 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 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 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 disposal of records must be requested and approved by United if the Agreement is continuous.

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 at no cost to all financial records and records pertaining to services provided to Members, both during and after the term of the Agreement. Provider shall provide immediate access to facilities, records and supportive materials pertinent to the State Contract for State or Federal fraud investigators.

s. Member Rights and Responsibilities. Provider shall comply with all Member rights and responsibilities outlined in 42 C.F.R. § 482.13 and NMAC § 8.308.8.11, which rights and responsibilities United will provide to Members through the Member Handbook.

iv) Stark Law and the Anti-Kickback Statute. 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 (see, 42 U.S.C. 1395nn; 42 U.S.C. 1320a–7b; 42 C.F.R. § 411.350).

3.4 Requirements for Specific Provider Types. The following provisions apply to certain provider types as indicated:

i) **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 C.F.R. §§ 417.436(d), 422.128, and 438.3(j).

ii) **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 United. 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.

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

iv) **Mental Health and Substance Use Providers.** Providers who provide Mental Health and Substance Use services to Covered Persons must provide for services to be delivered in compliance with the requirements of 42 CFR 438.3 subpart K insofar as those requirements are applicable.

v) **Long-Term Services and Supports (LTSS) Providers.** Any LTSS Covered Services under the State Contract that could be authorized through a waiver under section 1915(c) of the Social Security Act (the "Act") or a State Program amendment authorized through sections 1915(i) or 1915(k) of the Act must be delivered in settings consistent with 42 C.F.R. § 441.301(c)(4)-(5).

vi) **Utilization Management.** Provider shall comply with State and federal requirements for utilization management, including but not limited to, 42 C.F.R. § 438.910(d) and 42 C.F.R. part s456.

vii) **Credentialing.** Meet State and federal regulations for credentialing and recredentialing, including 42 C.F.R. § 455.104, § 455.105, § 455.106, § 455.107 and § 1002.3(b).

viii) **Nursing Facility (NF).** NF Providers shall promptly notify United of: (i) a Member's admission, or request for admission to the NF regardless of payor source for the NF stay; (ii) a change in a Member's known circumstances; and (iii) a Member's pending discharge.

NF Providers shall notify the Member and/or the Member's Representative in writing prior to discharge in accordance with 42. C.F.R. § 483.15(c) and must notify the Member's care coordinator of any change in a Member's medical or functional condition that could impact the Member's level of care determination.

ix) **Primary Care Providers (PCPs).** If Provider is a PCP Provider, Provider will comply will with all PCP requirements set forth by the State, including but not limited to:

I. The PCP shall ensure coordination and continuity of care with Providers, including all Behavioral Health and LTC Providers, according to United's policy; and

II. The PCP shall ensure that the Member receives appropriate prevention services based on the Member's age group, gender, and risk factors.

III. PCPs shall refer Members for behavioral services based on the following indicators:

- Suicidal/homicidal ideation or behavior;
- At-risk of hospitalization due to a behavioral health condition;
- Children or adolescents at imminent risk of out-of-home placement in a psychiatric acute care hospital or residential treatment facility;
- Trauma victims;
- Serious threat of physical or sexual abuse or risk to life or health due to impaired mental status and judgment. or other intellectual and developmental disabilities;
- Request by Member or representative for behavioral health services;
- Clinical status that suggests the need for behavioral health services;
- Identified psychosocial stressors and precipitants;
- Treatment compliance complicated by behavioral characteristics;
- Behavioral and psychiatric factors influencing medical condition;
- Victims or perpetrators of abuse and/or neglect and Members suspected of being subject to abuse and/or neglect;
- Non-medical management of substance abuse;
- Follow-up to medical detoxification;
- An initial PCP contact or routine physical examination indicates a substance abuse problem;
- A prenatal visit indicates substance abuse problems;
- Positive response to questions indicates substance abuse, observation of clinical indicators, or laboratory values that indicate substance abuse;
- A pattern of inappropriate use of medical, surgical, trauma, or emergency room services that could be related to substance abuse or other behavioral health conditions; and/or
- The persistence of serious functional impairment associated with a primary behavioral health disorder.

x) **Community Benefit Providers**. If Provider is a Community Benefit Provider, Provider will comply with all applicable requirements set forth by the State, including but not limited to:

I. Providers must provide at least thirty calendar days' advance notice to United when Provider is no longer willing or able to provide services to a Member, including the reason for the decision, and must cooperate with the Member's care coordinator to facilitate a seamless transition to alternate Providers.

II. Provider must comply with all applicable Home and Community Based settings requirements.

III. Provider must immediately report any deviation from the Member's service schedule to the Member's care coordinator.

IV. As a condition of payment, Community Benefit Providers must ensure that services are provided to eligible Members in accordance with applicable State and federal requirements and the Member's care plan.

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

SECTION 4 UNITED REQUIREMENTS

4.1 Prompt Payment. United shall pay Provider pursuant to the State Contract and applicable State and federal law and regulations, including but not limited to 42 C.F.R. § 447.46 and NMAC § 13.10.28.9. 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 United otherwise requests assistance from Provider, United will be responsible for third party collections in accordance with the terms of the State Contract.

4.3 Provider Discrimination Prohibition. United will not discriminate in the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. In addition, United will not discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatment. This provision shall not be construed as prohibiting United 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 United that are designed to maintain quality of care practice standards and control costs.

4.4 Provider-Member Communications. United may 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; or (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.

United also 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.

4.5 **Federally Qualified Health Clinic (FQHC) and Rural Health Clinic (RHC) Payment**. If HSD assigns Provider to an FQHC or RHC Provider Type, United will reimburse Provider at a minimum of the Prospective Payment System (PPS) or alternative payment methodology in compliance with Section 1905(a)(2)(C) of the Social Security Act.

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. The provisions of the State Contract

applicable to Provider are incorporated into the Agreement by reference. Nothing in the Agreement relieves United 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 Enrollment. The parties acknowledge and agree that the State Program is responsible for enrollment, reenrollment and disenrollment of Members.

5.3 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 United or as prohibiting or penalizing United for contracting with other providers

5.4 Delegation. Any delegated duties and reporting responsibilities shall be set forth in the Agreement or other written delegation agreement or addendum between the parties.

5.5 Regulatory Amendment. United may unilaterally amend this Appendix to comply with applicable laws and regulations and the requirements of applicable regulatory authorities including, but not limited to, Medicaid Agency. Unless such laws, regulations, or regulatory authority(ies) direct otherwise, the signature of Provider will not be required in order for the amendment to take effect.

SECTION 6 STATE SPECIFIC REQUIREMENTS

6.1 Medically Necessary or Medical Necessity. In addition to Section 3.1(iii) and as required by the State Contract, Medically Necessary or Medical Necessity means Physical Health, Behavioral Health, and LTSS, and supplies, that: (i) are essential to prevent, diagnose or treat medical conditions or are essential to enable the Member to attain, maintain, or regain the Member's optimal functional capacity; (ii) are delivered in the amount, duration, scope and setting that are both sufficient and effective to reasonably achieve their purposes and clinically appropriate to the specific Physical Health, Behavioral Health, and LTC needs of the Member; (iii) are provided within professionally accepted standards of practice and national guidelines; (iv) are required to meet the Physical Health, Behavioral Health, and LTC needs of the Member and are not primarily for the convenience of the Member, the Provider, or United; and (v) are reasonably expected to achieve appropriate growth and development as directed by HSD.

6.2 Clean Claims. For Claims from I/T/Us, day activity Providers, assisted living Providers, NFs and home care agencies, including Community Benefit Providers, United will adjudicate ninety-five percent (95%) of Clean Claims within a time period of no greater than fifteen (15) Calendar Days of receipt and ninety-nine percent (99%) or more of Clean Claims within a time period of no greater than thirty (30) Calendar Days of receipt.

For all other Claims, except Claims which have undergone a prepayment review, United will adjudicate ninety percent (90%) of all Clean Claims within thirty (30) Calendar Days of receipt and ninety-nine percent (99%) of all Clean Claims must within ninety (90) Calendar Days of receipt.

6.3 Termination, Revocation and Sanctions. In addition to its termination rights under the Agreement,

United shall have the right to revoke any functions or activities United delegates to Provider under the Agreement or impose other sanctions consistent with 42 CFR 438.230 (c)(iii) if in United's reasonable judgment Provider's performance under the Agreement is inadequate. United shall also have the right to suspend, deny, refuse to renew or terminate Provider from participation for any violation of applicable State or federal statutes and regulations, whether or not such violation results in criminal charges or sanctions...

In addition, the HCA reserves the right to direct United to terminate or modify the Provider agreement when the state determines it to be in their best interest.

6.4 Records Upon Termination. In addition to section 3.3 (iii)(r) above, in the event of termination of the state contract with United, Provider shall immediately make available to the State or its designated representative in a usable form, any or all records, whether medial or financial, related to the Provider's activities undertaken pursuant to the Provider's agreement with United. Such records shall be at no expense to the State.

6.5 Gratuities. Pursuant to the State's statutes and regulations, the receipt or solicitation of gratuities in the form of entertainment, gifts, or otherwise to any officer or employee of the State is strictly prohibited.

6.6 Conflict of Interest. Provider shall comply with all applicable provisions of the New Mexico Government Conduct Act, Chapter 10, Article 16 NMSA 1978 and 42 C.F.R. § 438.58.

6.7 Indemnification. To the extent applicable to Provider in performance of the Agreement, Provider shall indemnify, defend and hold the State and its employees harmless from and against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses, including court costs 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. The State 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.

6.8 Third-Party Beneficiary. Provider is not a third-party beneficiary to United's agreement with the State. Provider is an independent contractor performing services as outlined in Provider's agreement with United.

6.9 Notice to Member. Provider must, within its facilities, display notices to Members rights to grievances, appeals and state fair hearings, as required by the State.

6.10 Authorization of Emergency Services. Prior authorization will not be required for Provider to render Emergency Services to Member.

6.11 Record Retention. In addition to section 3.3(iii)(r) above, Provider shall make all Member medical records or other service records available for the purpose of quality review conducted by the State, or their designated agents both during and after the term of the Provider agreement. Such records shall be provided to the State within 2 to 10 business days after the date of the State's request in accordance with NMSA 1978, § 27-11- 4(B).

6.12 Provider Initiated Termination. Agency-based community benefit Providers shall provide at least thirty (30) calendar days advance notice to United when the Provider is no longer willing or able to provide services to a Member, including the reason for the decision, and to cooperate with the Member's care coordinator to facilitate a seamless transition to alternate providers.

6.13 Screening. In addition to section 3.2 (ii), Provider shall conduct screening of all employees, including those providing direct services to Members (e.g., home health, personal care), in accordance with the Employee Abuse Registry Act, NMSA 1978, § 27- 7A- 3, the New Mexico Caregivers Criminal History Screening Act, NMSA 1978, 29-17-2 et seq., and ensure that all employees are screened against the New Mexico "List of Excluded Individuals/Entities" and the Medicare exclusion databases. Provider shall also not employ or contract with providers excluded from participation in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act, unless otherwise granted by federal authority.

6.14 Native American Cost Sharing. Provider shall not impose any enrollment fee, premium or similar charge and shall not impose any deductible, copayment, cost sharing or similar charge to Members who are Native American, who were furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or by a Provider through referral under contract health services for which Medicaid payment may be made.

6.15 Children in State Custody (CISC). Comprehensive Community Support Services (CCSS) and High Fidelity Wraparound (HFW) Providers shall not reject nor eject Members who are CISC from any identified Behavioral Health Provider agreements.

No reject means that Provider must accept a CISC member's referral for eligibility and medical necessity determination. If the member is Medicaid eligible, meets the Serious Emotional Disturbance (SED) criteria, and meets medical necessity, Provider must coordinate all needed services through CCSS and HFW service providers for CISC. Provider must not discriminate against nor use any policy or practice that has the effect of discrimination against an individual on the basis of health status or need for services.

No eject means Provider must continue to coordinate services and assist CISC members in accessing appropriate services and supports.

In addition, Behavioral Health Providers who see CISC members shall deliver staff training on the following topics:

a) Trauma responsive training as approved by HCA
b) No reject and no eject provisions as noted above;
c) In-state accredited residential treatment centers (ARTCs), residential treatment centers (RTCs), group homes, and treatment foster care (TFC) providers must inform the United if a CISC Member is not accepted into service(s) or if a CISC Member is prematurely discharged

6.16 Health Information Exchange (HIE) As applicable, Behavioral Health and Physical Health Providers shall use the HIE for the secure sharing of clinical information between Physical and Behavioral Health Providers.

6.17 Behavioral Health Disaster Planning. Provider must participate in United's disaster Behavioral Health planning efforts at Provider's local area level.

6.18 Telemedicine. Provider must participate in United's telemedicine training requirements and follow HIPAA and 42 C.F.R. part 2 regulations regarding telemedicine transmission.