SOUTH CAROLINA STATE PROGRAM

REGULATORY REQUIREMENTS APPENDIX

DOWNSTREAM PROVIDER

THIS SOUTH CAROLINA STATE PROGRAM REGULATORY REQUIREMENTS APPENDIX (this "Appendix") supplements and is made part of the provider agreement (referred to in this Appendix as the "Agreement" or "Subcontract") between United Behavioral Health ("Subcontractor") and the provider named in the Agreement ("Provider").

SECTION 1
APPLICABILITY

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

The language set forth in Section 3 through Section 10 (with applicable defined terms) is required by the South Carolina Department of Health and Human Services (SCDHHS, heretofore referred to as the Department) as a condition of participation in the Medicaid program as a subcontractor of a Managed Care Organization. To the extent that any provision of the Agreement or this Appendix conflicts with any provision or requirement set forth within those Sections, the Department required language shall be controlling. Any other provision in this Agreement notwithstanding, in the event that the Department shall modify, amend, or otherwise change the required subcontract language, as set forth in the MCO Agreement, Provider understands and agrees that the Department required subcontract boilerplate shall be amended to conform to the Department's requirements and standards, without the need for a signed, written amendment.

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 **Affiliate:** Those entities controlling, controlled by, or under common control with Health Plan.

2.2 **Action:** As related to Grievance, either (1) the denial or limited authorization of a requested service, including the type or level of service; (2) the reduction, suspension, or termination of a previously authorized service; (3) the denial, in whole or in part, of payment for a service; (4) the failure to provide services in a timely manner, as defined by the Department; (5) the failure of the Contractor to act within the timeframes provided in §9.7.1 of the MCO Contract; or (6) for a resident of a rural area with only one Contractor, the denial of a Medicaid Managed Care Member's request to exercise his or her right, under 42 CFR §438.52(b)(2)(ii), to obtain services outside the Contractor's network.

2.3 **Additional Services**: A service(s) provided by the Contractor that is a non-covered service(s) by the South Carolina State Plan for Medical Assistance and is offered to Medicaid Managed Care Members in accordance with the standards and other requirements set forth in the Department's Medicaid Managed Care Contract that are outlined in another section of this Agreement.

2.4 **Administrative Services Contracts or Administrative Services Subcontracts:** Are Subcontracts or agreement that include but are not limited to: 1) any function related to the management of the Medicaid Managed Care Contract with the Department; 2) Claims processing including pharmacy claims; 3) credentialing including those for only primary source verification; 4) all Management Service Agreements; and 5) all Service Level Agreements (SLAs) with any Division of Subsidiary of a corporate parent owner.

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

2.6 **Clean Claim:** A claim that can be processed without obtaining additional information from the Provider of the service or from a third party.

2.7 **Continuity of Care:** The continuous treatment for a condition (such as pregnancy) or duration of illness from the time of first contact with a healthcare Provider through the point of release or long-term maintenance.

2.8 **Covered Services:** Health care services or products for which a Medicaid Managed Care Member is enrolled with Health Plan to receive coverage under the State Contract.

2.9 **Department:** The South Carolina Department of Health and Human Services (SCDHHS).

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

2.11 **Emergency Services:** Covered inpatient and outpatient services that are as follows: (1) furnished by a provider that is qualified to furnish these services under this title; and (2) needed to evaluate or stabilize an Emergency Medical Condition.

2.12 **Federal Qualified Health Center (FQHC):** A South Carolina licensed health center certified by the Centers for Medicare and Medicaid Services that receives Public Health Services grants. An FQHC provides a wide range of primary care and enhanced services in a medically under-served area.

2.13 **Grievance:** An expression of dissatisfaction about any matter other than an Action. The term is also used to refer to the overall system that includes Grievances and appeals handled at the Contractor level. (Possible subjects for Grievances 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 Medicaid Managed Care Member's rights.)

2.14 **Health Plan:** An appropriately licensed entity that has entered into a contract with Subcontractor, either directly or indirectly, under which Subcontractor provides certain services for Health Plan pursuant to the State Contract. For purposes of this Appendix, Health Plan refers to UnitedHealthcare of South Carolina, Inc.

2.15 **Managed Care Organization (MCO):** An entity that has, or is seeking to qualify for, a comprehensive risk contract that is (1) a Federally qualified HMO that meets the advance directive requirements of subpart I of 42 CFR Part 489; or (2) any public or private entity that meets the advance directives requirements and is determined to also meet the following conditions: (a) makes the services it provides to its Medicaid Managed Care Members as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid recipients within the area serviced by the entity; and (b) meets the solvency standards of 42 CFR §438.116. This includes any of the entity's employees, affiliated Providers, agents, or Contractors.

2.16 **Management Service Agreements:** A type of Subcontract with an entity in which the owner of the Contractor delegates some or all of the comprehensive management and administrative services necessary for the operation of the Contractor.

2.17 **Medically Necessary Service**: Those medical services which: (a) are essential to prevent, diagnose, prevent the worsening of, alleviate, correct or cure medical conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or aggravate a handicap, or result in illness or infirmity of a Medicaid Managed Care Member; (b) are provided at an appropriate facility and at the appropriate level of care for the treatment of the Medicaid Managed Care Member's medical condition; and, (c) are provided in accordance with generally accepted standards of medical practice.

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

2.19 **Medicaid Managed Care Member:** An eligible person(s) who is enrolled with a Department approved Medicaid Managed Care Organization (MCO, a.k.a. Contractor). For purpose of this Subcontract, Medicaid Managed Care Member shall include the patient, parent(s), guardian,

spouse or any other person legally responsible for the Medicaid Managed Care Member being served.

2.20 **Medicaid Provider**: A Provider of healthcare services or products which includes but is not limited to an institution, facility, agency, person, corporation, partnership, practitioner, specialty physician, group or association approved by the Department, licensed and/or credentialed which accepts as payment in full for providing benefits to Medicaid Managed Care Members amounts pursuant to the Contractor's reimbursement provisions, business requirements and schedules.

2.21 **Minimum Subcontract Provision (MSP):** Minimum Service Provisions are detailed in Sections 9 and 10 below.

2.22 **Primary Care Provider (PCP):** The Provider, serving as the entry point into the health care system, for the Medicaid Managed Care Member responsible for providing primary care, coordinating and monitoring referrals to specialist care, authorizing hospital services, and maintaining Continuity of Care.

2.23 **Rural Health Clinic (RHC):** A South Carolina licensed Rural Health Clinic is certified by the Centers for Medicare and Medicaid Services and receiving Public Health Services grants. An RHC is eligible for state defined cost based reimbursement from the Medicaid fee-for-service program. An RHC provides a wide range of primary care and enhanced services in a medically underserved area.

2.24 **Provider:** The Healthcare Medicaid Provider who is providing services for the Subcontractor under this Agreement.

2.25 **Service Level Agreement (SLA):** A type of Subcontract with a corporate owner or any of its Divisions or Subsidiaries that requires specific levels of service for administrative functions or services for the Contractor specifically related to fulfilling the Contractor's obligations to the Department under the terms of this Agreement.

2.26 **State:** The State of South Carolina or its designated regulatory agencies.

2.27 **State Contract:** A contract between Health Plan and Department for the purpose of providing and paying for Covered Services to Medicaid Managed Care Members enrolled in the State Program.

2.28 **State Program:** The Medicaid program, CHIP program and, as applicable, benefit plans for other state-based healthcare programs for low income individuals, developed and administered by the State. For purposes of this Appendix, State Program may refer to the State agency(ies) responsible for administering the applicable State Program.

SECTION 3
ADMINISTRATIVE REQUIREMENTS

3.1 The Department retains the right to review any and all Subcontracts entered into for the provision of any services under this Agreement.

3.2 The Department does not require the Provider to participate in any other line of business (i.e. Medicare Advantage or commercial) offered by the Subcontractor in order to enter into a business relationship with the Subcontractor.

3.3 The Department does not require the Provider to participate in the Network of any other Managed Care Organization as a condition of doing business with Subcontractor.

3.4 The Subcontractor and the Provider shall be responsible for resolving any disputes that may arise between the two (2) parties, and no dispute shall disrupt or interfere with the Continuity of Care of a Medicaid Managed Care Member. Provider recognizes and agrees that it does not have a right to a State Fair Hearing before the Department's Division of Appeals and Hearings.

3.5 The Provider represents and covenants that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of its services hereunder. The Provider further covenants that, in the performance of this Agreement, no person having any such known interests shall be employed.

3.6 The Provider recognizes that in the event of termination of the Department's Medicaid Managed Care Contract between the Health Plan and Department, the Health Plan is required to make available to the Department or its designated representative, in a usable form, any and all records, whether medical or financial, related to the Health Plan's, Subcontractor's and Provider's activities undertaken pursuant to this Agreement. The Provider agrees to furnish any records to the Health Plan or Subcontractor that the Health Plan would need in order to comply with this provision. The provision of such records shall be at no expense to the Department.

3.7 In the event of termination of this Subcontract, the Department must be notified of the intent to terminate this Agreement one hundred and twenty (120) calendar days prior to the effective date of termination. The date of termination will be at midnight on the last day of the month of termination.

3.8 If the termination of this Agreement is as a result of a condition or situation that would have an adverse impact on the health and safety of Medicaid Managed Care Members, the termination shall be effective immediately and the Department will be immediately notified of the termination and provided any information requested by Department.

3.9 The Health Plan or Subcontractor and Provider shall develop, maintain and use a system for Prior Authorization and Utilization Management that is consistent with this Subcontract.

SECTION 4
HOLD HARMLESS

4.1 At all times during the term of this Agreement, the Provider shall, except as otherwise prohibited or limited by law, indemnify, defend, protect, and hold harmless the Department and any of its officers, agents, and employees from:

i) Any claims for damages or losses arising from services rendered by any subcontractor, person, or firm performing or supplying services, materials, or supplies for the Provider in connection with the performance of this Agreement;

ii) Any claims for damages or losses to any person or firm injured or damaged by erroneous or negligent acts, including disregard of state or federal Medicaid regulations or legal statutes, by the Provider, its agents, officers, employees, or subcontractors in the performance of this Agreement;

iii) Any claims for damages or losses resulting to any person or firm injured or damaged by Provider, its agents, officers, employees, or subcontractors by the publication, translation, reproduction, delivery, performance, use, or disposition of any data processed under this Agreement in a manner not authorized by the Agreement or by federal or state regulations or statutes;

iv) Any failure of the Provider, its agents, officers, employees, or subcontractors to observe the federal or state laws, including, but not limited to, labor laws and minimum wage laws;

v) Any claims for damages, losses, or costs associated with legal expenses, including, but not limited to, those incurred by or on behalf of the Department in connection with the defense of claims for such injuries, losses, claims, or damages specified above;

vi) Any injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against the Department or their agents, officers or employees, through the intentional conduct, negligence or omission of the Provider, its agents, officers, employees or subcontractors.

4.2 As required by the South Carolina Attorney General (SCAG), in circumstances where the Provider is a political subdivision of the State of South Carolina, or an affiliate organization, except as otherwise prohibited by law, neither Provider nor the Department shall be liable for any claims, demands, expenses, liabilities and losses (including reasonable attorney's fees) which may arise out of any acts or failures to act by the other party, its employees or agents, in connection with the performance of services pursuant to this Agreement.

4.3 It is expressly agreed that the Subcontractor, Provider and agents, officers, and employees of the Subcontractor or Provider in the performance of this Agreement shall act in an independent capacity and not as officers and employees of the Department or the State of South Carolina. It is further expressly agreed that this Agreement shall not be construed as a partnership or joint venture between the Subcontractor or Provider and the Department and the State of South Carolina.

SECTION 5
LAWS

5.1 The Provider shall recognize and abide by all state and federal laws, regulations and the Department’s guidelines applicable to the provision of services under the Medicaid Managed Care Program.

5.2 The Provider must comply with all applicable statutory and regulatory requirements of the Medicaid program and be eligible to participate in the Medicaid program.

5.3 This Subcontract shall be subject to and hereby incorporates by reference all applicable federal and state laws, regulations, policies, and revisions of such laws or regulations shall automatically be incorporated into the Subcontract as they become effective.

5.4 The Provider represents and warrants that it has not been excluded from participation in the Medicare and/or Medicaid program pursuant to §§ 1128 (42 U.S.C. 1320a-7) (2001, as amended) or 1156 (42 U.S.C. 1320 c-5) (2001, as amended) of the Social Security Act or is not otherwise barred from participation in the Medicaid and/or Medicare program.

5.5 The Provider also represents and warrants that it has not been debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from non-procurement activities under regulations issued under Executive Orders.

5.6 The Provider shall not have a Medicaid contract with the Department that was terminated, suspended, denied, or not renewed as a result of any action of Center for Medicare and Medicaid Services (CMS), United States Department of Health and Human Services (HHS), or the Medicaid Fraud Unit of the Office of the South Carolina Attorney General. Providers who have been sanctioned by any state or federal controlling agency for Medicaid and/or Medicare fraud and abuse and are currently under suspension shall not be allowed to participate in the Medicaid Managed Care Program. In the event the Provider is suspended, sanctioned or otherwise excluded during the term of this Agreement, the Provider shall immediately notify the Subcontractor in writing.

5.7 The Provider ensures that it does not employ individuals who are debarred, suspended, or otherwise excluded from participating in federal procurement activities and/or have an employment, consulting, or other Agreement with debarred individuals for the provision of items and services that are significant to the Contractor's contractual obligation.

5.8 The Provider shall check the Excluded Parties List Service administered by the General Services Administration, when it hires any employee or contracts with any subcontractor, to ensure that it does not employ individuals or use Providers who are debarred, suspended, or otherwise excluded from participating in federal procurement activities and/or have an employment, consulting, or other contract with debarred individuals for the provision of items and services that are significant to Provider's contractual obligation. The Provider shall also report to the Subcontractor any employees or subcontractors that have been debarred, suspended, and/or excluded from participation in Medicaid, Medicare, or any other federal program.

5.9 In accordance with 42 CFR §455.104 (2010, as amended), the Provider agrees to provide full and complete ownership and disclosure information with the execution of this Agreement and to report any ownership changes within thirty-five (35) calendar days to the Subcontractor. Provider must download the appropriate form from the Health Plan or Subcontractor's website or request a printed copy be sent. Failure by the Provider to disclose this information may result in termination of this Agreement.

5.10 It is mutually understood and agreed that all contract language, specifically required by the Department, shall be governed by the laws and regulations of the State of South Carolina both as to interpretation and performance by Provider. Any action at law, suit in equity, or judicial

proceeding for the enforcement of the Department required language shall be instituted only in the courts of the State of South Carolina.

SECTION 6
AUDIT, RECORDS AND OVERSIGHT

6.1 The Provider shall maintain an adequate record system for recording services, service Providers, charges, dates and all other commonly accepted information elements for services rendered to Medicaid Managed Care Members pursuant to this Agreement (including, but not limited to, such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed). Medicaid Managed Care Members and their representatives shall be given access to and can request copies of the Medicaid Managed Care Members' health records, to the extent and in the manner provided by S.C. Code Ann. §44-115-10 et. seq., (Supp. 2000, as amended).

6.2 The Department (SCDHHS), HHS, CMS, the HHS Office of Inspector General, the State Comptroller, the State Auditor's Office, and the South Carolina Attorney General's (SCAG) Office, or any of their designees shall have the right to evaluate, through audit, inspection, or other means, whether announced or unannounced, any books, contracts, computer or other electronic systems of Provider (or any subcontractor of Provider) that pertain to any aspects of services and activities performed, or determination of amounts payable, under Subcontractor's contract with the, including those pertaining to quality, appropriateness and timeliness of services and the timeliness and accuracy of encounter data and claims submitted to the Subcontractor.

i) The Provider shall cooperate with these evaluations and inspections. The Provider will make office workspace available for any of the above-mentioned entities or their designees when the entities are inspecting or reviewing any records related to the provision of services under this Agreement. Provider will make available, for purposes of an audit, evaluation or inspection, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid enrollees.

ii) The right to audit Provider will exist through ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later. If the State, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate, and audit the Provider at any time.

6.3 The Provider will allow the Department and the U.S. Department of Health and Human Services, HHS, or their designee, to inspect and audit any financial records and/or books pertaining to: 1) the ability of the Provider to ear the risk of financial loss; and 2) services performed or payable amounts under the contract.

6.4 Whether announced or unannounced, the Provider shall participate and cooperate in any internal and external quality assessment review, utilization management, and Grievance procedures established by the Health Plan, Subcontractor or their designee.

6.5 The Provider shall comply with any plan of correction initiated by the Health Plan or Subcontractor and/or required by the Department.

6.6 All records originated or prepared in connection with the Provider's performance of its obligations under this Agreement, including, but not limited to, working papers related to the preparation of fiscal reports, health records, progress notes, charges, journals, ledgers, and electronic media, will be retained and safeguarded by the Provider in accordance with the terms and conditions of this Agreement. The Provider agrees to retain all financial and programmatic records, supporting documents, statistical records and other records of Medicaid Managed Care Members relating to the delivery of care or service under this Agreement, and as further required by the Department, for a period of five (5) years from the expiration date of the Agreement, including any Agreement extension(s). If any litigation, claim, or other actions involving the records have been initiated prior to the expiration of the five (5) year period, the records shall be retained until completion of the action and resolution of all issues which arise from it or until the end of the five (5) year period, whichever is later. If Provider stores records on microfilm or microfiche, the Provider must produce, at its expense, legible hard copy records upon the request of state or federal authorities, within fifteen (15) calendar days of the request.

6.7 The Department and/or any designee will also have the right to:

i) Inspect and evaluate the qualifications and certification or licensure of Provider and subcontractors;

ii) Evaluate, through inspection of Provider's facilities or otherwise, the appropriateness and adequacy of equipment and facilities for the provision of quality health care to Medicaid Managed Care Members;

iii) Audit and inspect any of Provider's records that pertain to health care or other services performed under this Agreement, determine amounts payable under this Agreement;

iv) Audit and verify the sources of encounter data and any other information furnished by Provider or Subcontractor in response to reporting requirements of this Agreement or the Department's Medicaid Managed Care Agreement, including data and information furnished by subcontractors.

6.8 Provider shall release health records of Medicaid Managed Care Members, as may be authorized by the Medicaid Managed Care Member or as may be directed by authorized personnel of the Department, appropriate agencies of the State of South Carolina, or the United States Government. Release of health records shall be consistent with the provisions of confidentiality as expressed in this Agreement.

6.9 Provider shall maintain up-to-date health records at the site where medical services are provided for each Medicaid Managed Care Member for whom services are provided under this Agreement. Each Medicaid Managed Care Member's record must be legible and maintained in detail consistent with good medical and professional practice that permits effective internal and external quality review and/or medical audit and facilitates an adequate system of follow-up treatment. The Department's representatives or designees shall have immediate and complete access to all records pertaining to the health care services provided to the Medicaid Managed Care Member.

SECTION 7

SAFEGUARDING INFORMATION

7.1 The Provider shall safeguard information about Medicaid Managed Care Members according to applicable state and federal laws and regulations including but not limited to 42 CFR 431, Subpart F, and Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164.

7.2 The Provider shall assure that all material and information, in particular information relating to Medicaid Managed Care Members, which is provided to or obtained by or through the Provider's performance under this Agreement, whether verbal, written, electronic file, or otherwise, shall be protected as confidential information to the extent confidential treatment is protected under state and federal laws. Provider shall not use any information so obtained in any manner except as necessary for the proper discharge of its obligations and securement of its rights under this Agreement.

7.3 All information as to personal facts and circumstances concerning Medicaid Managed Care Members obtained by the Provider shall be treated as privileged communications, shall be held confidential, and shall not be divulged to third parties without the written consent of the Department or the Medicaid Managed Care Member, provided that nothing stated herein shall prohibit the disclosure of information in summary, statistical, or other form which does not identify particular individuals. The use or disclosure of information concerning Medicaid Managed Care Members shall be limited to purposes directly connected with the administration of this Agreement.

7.4 All records originated or prepared in connection with the Provider's performance of its obligations under this Agreement, including but not limited to, working papers related to the preparation of fiscal reports, health records, progress notes, charges, journals, ledgers, and electronic media, will be retained and safeguarded by the Provider in accordance with the terms and conditions of this Agreement.

SECTION 8
BILLING A MEDICAID MANAGED CARE MEMBER

8.1 The Provider may bill a Medicaid Managed Care Member only under the following circumstances:

i) Provider is a Provider of services and is seeking to renders services that are non-covered services and are not Additional Services, as long as the Provider provides to the Medicaid Managed Care Member a written statement of the services prior to rendering said services. This written statement must include: (1) the cost of each service, (2) an acknowledgement of the Medicaid Managed Care Member's responsibility for payment, and (3) the Medicaid Managed Care Member's signature; or

ii) Provider is a Provider of services and the service provided has a co-payment, as allowed by the Health Plan or Subcontractor, the Provider may charge the Medicaid Managed Care Member only the amount of the allowed co-payment, which cannot exceed the co-payment amount allowed by the Department.

8.2 In accordance with the requirements of S.C. Code Ann. § 38-33-130(b) (Supp. 2001, as amended), and as a condition of participation as a qualified Medicaid Provider, the Provider hereby agrees not to bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have recourse against, Medicaid Managed Care Members, or persons acting on their behalf, for health care services which are rendered to such Medicaid Managed Care Members by the Provider, and which are covered benefits under the Medicaid Managed Care Member's evidence of coverage. This provision applies to all covered health care services furnished to the Medicaid Managed Care Member for which the Department does not pay the Health Plan or the Health Plan does not pay the Subcontractor. Provider agrees that this provision is applicable in all circumstances including, but not limited to, non-payment by the Health Plan and/or Subcontractor and insolvency of the Health Plan and/or Subcontractor. The Provider further agrees that this provision shall be construed to be for the benefit of Medicaid Managed Care Members and that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between the Provider and such Medicaid Managed Care Members.

SECTION 9
HEALTHCARE SERVICES

9.1 The Provider shall ensure adequate access to the services provided under this Agreement in accordance with the prevailing medical community standards.

9.2 The services covered by this Agreement must be in accordance with the South Carolina State Plan for Medical Assistance under Title XIX of the Social Security Act, and the Provider shall provide these services to Medicaid Managed Care Members through the last day that this Agreement is in effect. All final Medicaid benefit determinations are within the sole and exclusive authority of the Department or its designee.

9.3 The Provider may not refuse to provide Medically Necessary Services or covered preventive services to Medicaid Managed Care Members for non-medical reasons.

9.4 The Provider shall render Emergency Services without the requirement of prior authorization of any kind.

9.5 The Provider shall not be prohibited or otherwise restricted from advising a Medicaid Managed Care Member about the health status of the Medicaid Managed Care Member or medical care or treatment for the Medicaid Managed Care Member's condition or disease, regardless of whether benefits for such care or treatment are provided under the Department's Medicaid Managed Care Agreement, if Provider is acting within the lawful scope of practice.

9.6 The Subcontractor shall not include covenant-not-to-compete requirements or exclusive Provider clauses in its Provider agreements. Specifically, the Subcontractor is precluded from requiring that the Provider not provide services for any other South Carolina Medicaid Managed Care Contractor. In addition, the Subcontractor shall not enter into subcontracts that contain compensation terms that discourage Provider or any other providers from serving any specific eligibility category. No provision in this Subcontract shall create a covenant-not-to-compete agreement or exclusive Provider clause.

9.7 The Provider must take adequate steps to ensure that Medicaid Managed Care Members with limited English skills receive, free of charge, the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under this Agreement in accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et. seq.) (2001, as amended) and it's implementing regulation at 45 C.F.R. Part 80 (2001, as amended).

9.8 The Provider shall provide effective Continuity of Care activities, if applicable, that seek to ensure that the appropriate personnel, including the PCP are kept informed of the Medicaid Managed Care Member's treatment needs, changes, progress or problems.

9.9 The Provider must adhere to the Quality Assessment Performance Improvement and Utilization Management (UM) requirements consistent with this Agreement. The Contractor is responsible for informing the Subcontractor of such requirements and procedures, including any reporting requirements.

9.10 The Provider shall have an appointment system for Medically Necessary Services that is in accordance with the standards in this Agreement and prevailing medical community standards.

9.11 The Provider shall not use discriminatory practices with regard to Medicaid Managed Care Members such as separate waiting rooms, separate appointment days, or preference to private pay patients.

9.12 The Provider must identify Medicaid Managed Care Members in a manner that will not result in discrimination against the Medicaid Managed Care Member in order to provide or coordinate the provision of all core benefits and/or Additional Services and out of plan services.

9.13 The Provider agrees that no person, on the grounds of handicap, age, race, color, religion, sex, or national origin, shall be excluded from participation in, or be denied benefits of the Health Plan or Subcontractor's program or be otherwise subjected to discrimination in the performance of this Agreement or in the employment practices of Provider. The Provider shall show proof of such non-discrimination, upon request, and shall post in conspicuous places, available to all employees and applicants, notices of non-discrimination.

9.14 If the Provider performs laboratory services, the Provider must meet all applicable state and federal requirements related thereto. All laboratory-testing sites providing services shall have either a CLIA certificate or waiver of a certificate of registration along with a CLIA identification number.

9.15 If the Provider is a hospital, Provider shall notify the Health Plan, Subcontractor and the Department of the births when the mother is a Medicaid Managed Care Member. The Provider shall also complete a Department request for Medicaid ID Number (Form 1716 ME), including indicating whether the mother is a Medicaid Managed Care Member, and submit the form to the local/state Department office.

9.16 If the Provider is an FQHC/RHC, Provider shall adhere to federal requirements for reimbursement for FQHC/RHC services. This Agreement shall specify the agreed upon payment from the Subcontractor to the FQHC/RHC. Any bonus or incentive arrangements made to the

FQHCs/RHCs associated with Medicaid Managed Care Members must also be specified and included this Agreement.

9.17 If the Provider is a PCP, the Provider shall have an appointment system for covered core benefits and/or Additional Services that is in accordance with prevailing medical community standards but shall not exceed the following requirements:

i) Routine visits scheduled within four (4) to six (6) weeks.

ii. Urgent, non-emergency visits within forty-eight (48) hours.

iii. Emergent or emergency visits immediately upon presentation at a service delivery site.

iv) Waiting times that do not exceed forty-five (45) minutes for a scheduled appointment of a routine nature.

v) Walk-in patients with non-urgent needs should be seen if possible or scheduled for an appointment consistent with written scheduling procedures.

vi) Walk-in patients with urgent needs should be seen within forty-eight (48) hours.

9.18 As a PCP, the Provider must also provide twenty-four (24) hour coverage but may elect to provide twenty-four (24) hour coverage by direct access or through arrangement with a triage system. The triage system arrangement must be prior approved by the Health Plan and/or Subcontractor.

9.19 The Provider shall submit all reports and clinical information required by the Health Plan and/or Subcontractor, including Early Periodic Screening, Diagnosis, and Treatment (EPSDT), if applicable.

SECTION 10
PAYMENT

10.1 Subcontractor, or its designee, shall be responsible for payment of services rendered to Medicaid Managed Care Members in accordance with this Subcontract and shall pay ninety percent (90%) of all Clean Claims from practitioners, either in individual or group practice or who practice in shared health facilities, within thirty (30) days of the date of receipt. The Subcontractor shall pay ninety-nine percent (99%) of all Clean Claims from practitioners, either in individual or group practice or who practice in shared health facilities, within ninety (90) days of the date of receipt. The date of receipt is the date the Contractor receives the claim, as indicated by its data stamp on the claim. The date of payment is the date of the check or other form of payment.

10.2 The Subcontractor and Provider may, by mutual written agreement, establish an alternative payment schedule to the one presented.

10.3 The Provider shall accept payment made by the Subcontractor as payment-in-full for covered services and Additional Services provided and shall not solicit or accept any surety or guarantee

of payment from the Medicaid Managed Care Member, except a specifically allowed by Section 8, Billing of Medicaid Managed Care Members.

10.4 No Subcontract shall contain any provision that provides incentives, monetary or otherwise, for the withholding of Medically Necessary Services.

10.5 Any incentive plans for Providers shall be in compliance with 42 CFR Part 434 (2009, as amended), 42 CFR § 417.479 (2008, as amended), 42 CFR §422.208 and 42 CFR §422.210 (2008, as amended).

SECTION 11
ADDITIONAL PROVIDER REQUIREMENTS

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

11.2 **Accessibility Standards.** Provider shall provide for timely access for Medicaid Managed Care Member appointments in accordance with the appointment availability requirements established under the State Contract, as further described in the applicable provider manual.

11.3 **Hold Harmless.** Except for any applicable cost-sharing requirements under the State Contract, Provider shall look solely to Subcontractor and/or Health Plan (as set forth in the Agreement) for payment of Covered Services provided to Medicaid Managed Care Members pursuant to the Agreement and the State Contract and hold the State, the U.S. Department of Health and Human Services and Medicaid Managed Care Members harmless in the event that Subcontractor and/or Health Plan, as applicable, cannot or will not pay for such Covered Services. In accordance with 42 CFR Part 447.15, as may be amended from time to time, the Medicaid Managed Care Member is not liable to Provider for any services for which Subcontractor or Health Plan is liable and as specified under the State's relevant health insurance or managed care statutes, rules or administrative agency guidance. Provider shall not require any copayment or cost sharing for Covered Services provided under the Agreement unless expressly permitted under the State Contract. Provider shall also be prohibited from charging Medicaid Managed Care Members for missed appointments if such practice is prohibited under the State Contract or applicable law. Neither the State, the Department nor Medicaid Managed Care Members shall be in any manner liable for the debts and obligations of Subcontractor or Health Plan and under no circumstances shall Provider, Subcontractor or Health Plan, or any providers used to deliver services covered under the terms of the State Contract, charge Medicaid Managed Care Members for Covered Services.

This provision shall survive any termination of the Agreement, including breach of the Agreement due to insolvency.

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

11.5 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.

11.6 Subcontracts. If Provider subcontracts or delegates any functions of the Agreement, in accordance with the terms of the Agreement, the subcontract or delegation must be in writing and include all of the requirements of this Appendix, applicable requirements of the State Contract, and applicable laws and regulations. Provider further agrees to promptly amend its agreements with such subcontractors, in the manner requested by Subcontractor or Health Plan, to meet any additional State Program requirements that may apply to the services.

11.7 Records Retention. As required under State or federal law or the State Contract, Provider shall maintain an adequate record keeping system for recording services, charges, dates and all other commonly accepted information elements for services rendered to Medicaid Managed Care 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 Medicaid Managed Care Member. Other records shall be maintained as necessary to clearly reflect all actions taken by Provider related to services provided under the State Contract.

11.8 Privacy; Confidentiality. In addition to the requirements set forth in Section 7 of this Appendix, Provider shall ensure that access to member identifying information shall be limited by Provider to persons or agencies that require the information in order to perform their duties in accordance with this Agreement, including the U.S. Department of Health and Human Services (HHS), the Department and other individuals or entities as may be required. (See 42 CFR §431.300, et seq. and 45 CFR Parts 160 and 164.) Any other party shall be granted access to confidential information only after complying with the requirements of state and federal laws, including but not limited to HIPAA, and regulations pertaining to such access. Provider is responsible for knowing and understanding the confidentiality laws listed above as well as any other applicable laws. Nothing herein shall prohibit the disclosure of information in summary, statistical or other form that does not identify particular individuals, provided that de-identification of protected health information is performed in compliance with the HIPAA Privacy Rule.

Federal and State Medicaid regulations, and some other federal and State laws and regulations, including but not limited to those listed above, are often more stringent than the HIPAA regulations. Provider shall notify Subcontractor, Health Plan and the Department of any breach of confidential information related to Medicaid Managed Care 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 Subcontractor, Health Plan and the Department with an investigation report within the time period required by applicable federal and State laws and regulations following the discovery. Provider shall work with Subcontractor, Health Plan and the Department to ensure that the breach has been mitigated and reporting requirements, if any, complied with.

11.9 Compliance with Law. Provider shall comply with all applicable federal and State laws regulations, policies and revisions of such laws or regulations shall automatically be incorporated into the Agreement as they become effective, 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; title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; Americans with Disabilities Act; section 1557 of the Patient Protection and Affordable Care Act; and their implementing regulations, as may be amended from time to time.

ii) 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."

iii) 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.

11.10 Compliance with State and Federal Laws and Regulations. Provider agrees to abide by all state and federal laws, regulations and the Department's guidelines to the extent applicable to Provider in Provider's performance of the Agreement. Provider understands that payment of a claim by Subcontractor, Health Plan or the State is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited to, federal requirements on fraud, waste and abuse, disclosure, debarment, termination and exclusion screening), and is conditioned on the Provider's compliance with all applicable conditions of participation in Medicaid. Provider understands and agrees that each claim the Provider submits to Subcontractor and/or Health Plan 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, Subcontractor or Health Plan provides notice that a credible allegation of fraud exists and there is a pending investigation. Provider's payment of a claim may also be temporarily suspended or adjusted if the Provider bills a claim with a code that does not match the service provided. Subcontractor and/or Health Plan performs coding edit procedures based primarily on National Correct Coding

Initiative (NCCI) policies and other nationally recognized and validated policies. Provider agrees that it will provide medical records to Subcontractor and/or Health Plan 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.

11.11 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 434 (2009, as amended),) 42 CFR 438.3, 42 CFR 422.208, and 42 CFR 422.210, as may be amended from time to time. Neither Subcontractor, Health Plan nor Provider may 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 Medicaid Managed Care Member. PIPs must not contain provisions that provide incentives, monetary or otherwise, for the withholding of services that meet the definition of Medically Necessary or Medical Necessity.

11.12 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. Section 1352 and 45 CFR Part 93, as may be amended from time to time, that no federally appropriated funds have been paid or will be paid to any person by or on Provider's behalf for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

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.

11.13 Excluded Individuals and Entities. In furtherance of the requirements set forth under Section 5 of this Appendix, by signing the Agreement, Provider certifies to the best of Provider's knowledge and belief 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 1156 of the Social Security Act or is not otherwise barred from participation in the Medicaid and/or Medicare program; or

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

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

11.14 Disclosure. In addition to the requirements set forth in Section 5.9 of this Appendix, Provider must be screened and enrolled into the State's Medicaid or CHIP program, as applicable, and submit disclosures to the Department on ownership and control, significant business transactions, and persons convicted of crimes, including any required criminal background checks, in accordance with 42 CFR Part 455 Subparts B and E. Additionally, Provider must cooperate with the Department for submission of fingerprints upon a request from the Department or CMS in accordance with 42 CFR 455.434.

11.15 Cultural Competency and Access. Provider shall participate in Subcontractor's, Health Plan's and the State's efforts to promote the delivery of services in a culturally competent manner to all Medicaid Managed Care 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 Medicaid Managed Care Member's primary language and for the hearing impaired for all appointments and emergency services. Provider shall provide information to Medicaid Managed Care Members regarding treatment options and alternatives, as well as information on complaints and appeals, in a manner appropriate to the Medicaid Managed Care Member's condition and ability to understand.

Provider shall provide physical access, reasonable accommodations, and accessible equipment for Medicaid Managed Care Members with physical or mental disabilities.

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

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

11.18 Fraud, Waste and Abuse Prevention. Provider shall cooperate fully with Subcontractor's and Health Plan's policies and procedures designed to protect program integrity and prevent and detect potential or suspected fraud, waste, and abuse in the administration and delivery of services under the State Contract and shall cooperate and assist the Department 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.

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

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

11.20 Encounter Data. Provider agrees to cooperate with Subcontractor and/or Health Plan to comply with Subcontractor and/or Health Plan's obligation to prepare timely encounter data submissions, reports, and clinical information including, without limitation, child and adolescent health check-up reporting, EPSDT encounters, and cancer screening encounters, as applicable, and such other reporting regarding Covered Services as may be required under the State Contract. Encounter data must be accurate and include all services furnished to a Medicaid Managed Care Member, including capitated provider's data and rendering provider information. Encounter data must be provided within the timeframes specified and in a form that meets Subcontractor, Health Plan and State requirements. By submitting encounter data to Subcontractor and/or Health Plan, Provider represents to Subcontractor and/or Health Plan that the data is accurate, complete and truthful, and upon Subcontractor's and/or Health Plan's request Provider shall certify in writing, that the data is accurate, complete, and truthful, based on Provider's best knowledge, information and belief.

11.21 Claims Information. Provider shall promptly submit to Subcontractor and/or Health Plan (as set forth in the Agreement) the information needed to make payment and shall identify third party liability coverage, including Medicare and other insurance, and, if applicable, shall seek such third party liability payment before submitting claims to Subcontractor and/or Health Plan. Provider understands and agrees that each claim Provider submits to Subcontractor and/or Health Plan 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 Medicaid Managed Care Member prior to submitting the claim.

11.22 Insurance Requirements. As applicable, Provider shall secure and maintain during the term of the Agreement insurance appropriate to the services to be performed under the Agreement.

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

11.24 Clinical Laboratory Improvements Act (CLIA) certification or waiver. In addition to the requirements set forth in Section 9.14, if Provider performs any laboratory tests on human specimens for the purpose of diagnosis and/or treatment, Provider must include the appropriate CLIA certificate or waiver number on claims submitted for payment for laboratory services.

11.25 Quality; Utilization Management. Pursuant to any applicable provider manuals and related protocols, or as elsewhere specified under the Agreement, Provider agrees to cooperate with

Subcontractor's and/or Health Plan'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 Subcontractor and/or Health Plan or as required under the State Contract to ensure that Medicaid Managed Care Members have due process for their complaints, grievances, appeals, fair hearings or requests for external review of adverse decisions made by Subcontractor and/or Health Plan or Provider. Provider shall adhere to the quality assurance and utilization review standards of the State Program and shall monitor quality and initiate corrective action to improve quality consistent with the generally accepted level of care.

11.26 Immediate Transfer. Provider shall cooperate with Subcontractor and Health Plan in the event an immediate transfer to another primary care physician or Medicaid managed care contractor is warranted if the Medicaid Managed Care Member's health or safety is in jeopardy, as may be required under law.

11.27 Transition of Covered Persons. In the event of transitioning Covered Persons from other Medicaid managed care contractors and their provider, Provider shall work with Subcontractor and Health Plan to ensure quality-driven health outcomes for such Medicaid Managed Care Members to the extent required by the State Contract or otherwise required by law.

11.28 Continuity of Care. Provider shall cooperate with Subcontractor and Health Plan and provide Medicaid Managed Care 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 Health Plan terminates during the course of a Medicaid Managed Care Member's treatment by Provider, except in the case of adverse reasons on the part of Provider.

11.29 Health Records. In addition to Provider's obligations under Section 6.8 of this Appendix, Provider agrees to cooperate with Subcontractor and/or Health Plan to maintain and share a health record of all services provided to a Medicaid Managed Care Member, as appropriate and in accordance with applicable laws, regulations and professional standards.

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

11.31 National Provider ID (NPI). If applicable, Provider shall obtain a National Provider Identification Number (NPI).

11.32 Termination of Agreement. In the event of termination of the Agreement, Provider shall promptly supply to Subcontractor and/or Health Plan all information necessary for the reimbursement of any outstanding claims for Covered Services.

11.33 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 Subcontractor and Health Plan any provider preventable conditions in

accordance with 42 CFR §§ 434.6(a) (12), 438, including but not limited to § 438.3(g),3g, and § 447.26.

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

SECTION 12
ADDITIONAL SUBCONTRACTOR AND/OR HEALTH PLAN REQUIREMENTS

12.1 Prompt Payment. As set forth in the Agreement, Subcontractor or Health Plan shall pay Provider pursuant to the State Contract and applicable State and federal law and regulations, including but not limited to Section 10 of this Appendix, 42 CFR 447.46, 42 CFR 447.45(d) (2), 42 CFR 447.45(d) (3), 42 CFR 447.45(d) (5) and 42 CFR 447.45(d) (6), as applicable and as may be amended from time to time. If a third party liability exists, payment of claims shall be determined in accordance with federal and/or State third party liability law and the terms of the State Contract. Unless Subcontractor or Health Plan otherwise requests assistance from Provider, Subcontractor or Health Plan will be responsible for third party collections in accordance with the terms of the State Contract.

12.2 No Incentives to Limit Medically Necessary Services. Neither Subcontractor nor Health Plan shall 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 Medicaid Managed Care Member.

12.3 Provider Discrimination Prohibition. Neither Subcontractor nor Health Plan shall 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. Neither Subcontractor nor Health Plan shall discriminate against Provider for serving high-risk Medicaid Managed Care Members or if Provider specializes in conditions requiring costly treatments. This provision shall not be construed as prohibiting Subcontractor or Health Plan from limiting a provider's participation to the extent necessary to meet the needs of Medicaid Managed Care Members. This provision also is not intended and shall not interfere with measures established by Subcontractor and/or Health Plan that are designed to maintain quality of care practice standards and control costs.

12.4 Communications with Medicaid Managed Care Members. Neither Subcontractor nor Health Plan shall prohibit or otherwise restrict Provider, when acting within the lawful scope of practice, from advising or advocating on behalf of a Medicaid Managed Care Member for the following:

i) The Medicaid Managed Care Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered and regardless of whether benefits for such care or treatment are provided under the State Contract;

ii) Any information the Medicaid Managed Care 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 Medicaid Managed Care 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.

Neither Subcontractor nor Health Plan shall prohibit a Provider from advocating on behalf of a Medicaid Managed Care Member in any grievance system, utilization review process, or individual authorization process to obtain necessary health care services.

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

SECTION 13
OTHER REQUIREMENTS

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

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

13.3 Enrollment. The parties acknowledge and agree that the State Program is responsible for enrollment, reenrollment and disenrollment of Medicaid Managed Care Members.

13.4 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 Health Plan or as prohibiting or penalizing Subcontractor and/or Health Plan for contracting with other providers.

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