UNITED BEHAVIORAL HEALTH
INDIVIDUAL PARTICIPATING PROVIDER AGREEMENT

THIS AGREEMENT is between United Behavioral Health ("UBH") and the undersigned provider (hereinafter referred to as the "Provider"). This Agreement will become effective upon the date set forth in UBH's executed Acceptance Letter (the "Effective Date"). This Agreement sets forth the terms and conditions under which Provider shall participate in one or more networks developed by UBH as a Participating Provider of Covered Services to Members.

ARTICLE 1
Definitions

Any capitalized term herein shall have the meaning as set forth in this Agreement. Any undefined term herein shall have the meaning as defined in the Provider Manual, the Protocols, or as may be defined by applicable state or federal laws or regulations, as applicable.

Affiliate: Each and every entity or business concern with which UBH, directly or indirectly, in whole or in part, either: (i) owns or controls; (ii) is owned or controlled by; or (iii) is under common ownership or control.

Benefit Plan: The specific plan of benefits for health care coverage, including MHSA Services, for a particular Member that is provided, sponsored or administered by UBH directly or through its Affiliate, or through a network rental arrangement UBH may have with a third party, and contains the terms and conditions of a Member's coverage for MHSA Services, including applicable Member Expenses, exclusions and limitations, and all other provisions applicable to the coverage of such MHSA Services such as services rendered outside specified networks.

CMHC: A Community Mental Health Center.

CMHC Provider: An employee of a CMHC who provides mental health and/or substance abuse services, but is not a CMHC Supervising Provider.

CMHC Supervising Provider: A psychiatrist, psychologist, social worker, family or other therapist duly licensed and qualified in the state in which MHSA Services are provided to Members who practices as an employee of CMHC and has been approved as a CMHC Supervising Provider in writing by UBH.

Covered Services: MHSA Services that meet the terms and conditions for coverage pursuant to the Member's Benefit Plan, including such conditions as Medically Necessary and proper authorization, and in accordance with the Provider Manual, Protocols, and applicable laws and regulations.

Customary Charge: The fee for MHSA Services charged by Provider that does not exceed the fee Provider would ordinarily charge any other person regardless of whether the person is a Member.

Emergency Services: Unless otherwise defined by applicable state law, a serious health condition that arises suddenly and requires immediate care and treatment, generally received within twenty-four (24) hours of onset, to stabilize or avoid jeopardy to the life or health of a Member or, by actions of the Member, to the life or health of another. Emergency Services shall be available twenty-four (24) hours per day, seven (7) days per week.

Fee Maximums: The maximum amount Provider may receive as payment for provision of Covered Services to a Member, including Member Expenses, that are applicable to Provider pursuant to the Benefit Plan, as determined from time to time by UBH. UBH will advise Provider of the then-current Fee Maximums to Provider upon request.

Medicaid: A Medical Assistance Program providing health coverage benefits for low income persons pursuant to applicable state and federal laws and regulations.

Medically Necessary: Except as otherwise required by applicable state or federal law or regulations, for purposes of this Agreement, Medically Necessary means the term as it may be described in the Member's Benefit Plan for MHSA Services and which meets Payor's defined criteria for coverage as Covered Services. It may also, when applicable, have the meaning defined within the Protocols. Generally, however, Medically Necessary means treatment that is commonly recognized in the industry as consistent treatment that must be: (a) solely to treat the condition of the Member; (b) for the illness or injury of a diagnosis that is commonly recognized as a disease or injury; (c) reasonably expected to directly result in the restoration of health or function; (d) not experimental or investigational but is consistent with established and accepted national medical practice guidelines regarding type, frequency and duration of treatment; (e) without alternative treatment that is less intensive or invasive for the efficient treatment of the Member's condition; (f) not based on convenience for the Member; and (g) not otherwise excluded from the definition of Covered Services based upon the terms and conditions of the Member's Benefit Plan.

Medicare: Federally sponsored program providing health coverage benefits to individuals of qualifying age, disability, or disease.

Member: An individual who is eligible for, properly enrolled in, and covered under a Benefit Plan.

Member Expenses: Any amount of Customary Charges that are the Member's responsibility to pay Provider in accordance with the terms of the Member's Benefit Plan, including co-payments, co-insurance and deductible amounts.

Mental Health and Substance Abuse Services ("MHSA Services"): Health care services, treatment or supplies that are used to treat a mental health or substance abuse illness, condition or disease and which may be eligible for coverage under the Member's Benefit Plan.

Participating Provider: A health care professional, facility, CMHC Supervising Provider, psychiatrist, psychologist or other behavioral health professional or

organization, that is duly licensed or certified to provide MHSA Services within the state such MHSA Services are provided, and who has a written Individual Participating Provider Agreement in effect with UBH, directly or through another entity, to provide MHSA Services to Members.

Payment Policies: Guidelines adopted by UBH, from time to time, for calculating payment of claims under Benefit Plans.

Payor: The entity or person that has the financial responsibility for funding payment of Covered Services on behalf of a Member, and that is authorized to access MHSA Services in accordance with this Agreement.

Protocols: The programs, policies, protocols, processes, procedures, and requirements as such may change or be modified from time to time, and that are adopted by UBH or Payor, and which Provider agrees to follow as a condition of UBH accepting Provider as a Participating Provider, including, but not limited to, authorization procedures, credentialing and re-credentialing processes and plans, utilization management and care management processes, billing procedures, Payment Policies, providing or arranging for Emergency Services, quality improvement, peer review, on-site review, Member grievance and appeals processes, and any other policies, procedures, processes, activities or standards, wherever located as may apply to Provider's rights, obligations or responsibilities as a Provider of MHSA Services, whether in this Agreement, Provider Manual, or any other document as made accessible or available to Provider from time to time.

Provider Manual: A document or manual, however known or named, such as the Network Manual, containing the administrative policies, procedures and Protocols applicable to Benefit Plans provided, sponsored or administered by UBH or a Payor including, but not limited to, policies and procedures for credentialing, claims, quality improvement, and utilization management to which Provider is obligated.

ARTICLE 2
Duties of Provider

2.1 Provision of MHSA Services. Provider hereby acknowledges and agrees to cooperate and comply with all of the terms and conditions of the Provider Manual, Protocols, and this Agreement, and to dutifully perform as a Participating Provider for the provision of MHSA Services to Members within the UBH network(s) as designated by UBH or Payor. At the request of a Payor, Provider may not be authorized to provide MHSA Services for some or all of Payor's Members. Provider shall otherwise accept Members as new patients on the same basis as Provider is accepting non-Members as new patients without regard to race, religion, gender, color, national origin, age or physical or mental health status, or on any other basis deemed unlawful under federal, state or local law. At all times, Provider shall require any employed or subcontracted health care professionals and facilities to comply with the terms and conditions of this Agreement, all Protocols of UBH and Payor, the Provider Manual, as well as the requirements of all applicable laws and regulations.

2.2 Benefit Plan & Eligibility. MHSA Services provided by Provider to a Member pursuant to this Agreement are subject to all the terms and conditions of the Member's Benefit Plan including eligibility of the Member on the date MHSA Services are provided to the Member. Provider shall make reasonable effort to verify Member's eligibility at time of service by following appropriate procedures, including without limitation, and at a minimum, the terms and conditions of this Agreement, Protocols, the Provider Manual, and review of the Member's Benefit Plan identification card. Provider however recognizes that the Member eligibility information may be inaccurate at the time Provider obtains verification and that the Member, or the MHSA Services provided to the Member, may later be determined to be ineligible for coverage and, except as otherwise required by law, not eligible for payment under this Agreement. Under such circumstances, Provider may then, except as otherwise stated herein, directly bill the Member or other responsible party for such MHSA Services.

2.3 Provider Manual & Protocols. Provider shall be bound by, accept, strictly comply with, and cooperate with, the requirements set forth in the Provider Manual, credentialing plan, and all Protocols, as amended or modified from time to time by UBH and/or Payor, all of which are hereby incorporated herein by reference as if set forth fully herein, including without limitation quality improvement activities. Provider acknowledges and agrees that the Provider Manual and/or Protocols may contain service and contract requirements of certain Payors to which Provider shall strictly comply. Provider's failure to comply with the Provider Manual, Protocols and any other standards, procedures or policies may result in loss of, or reduction of payment or reimbursement to Provider, termination of this Agreement or the imposition of other corrective action by UBH.

2.4 Authorization Requirements. Subject to all applicable terms and conditions, including without limitation Section 2.2 above, and in accordance with the Provider Manual, Protocols, and requirements of the Member’s Benefit Plan regarding authorization, Provider must request authorization for MHSA Services from UBH either telephonically or by another approved and accepted method recognized by UBH before providing any MHSA Services to a Member as a Covered Service. Authorizations shall subsequently be confirmed by UBH in writing. Except as otherwise permitted herein, only Emergency Services will be eligible for retroactive authorization at the sole discretion of UBH or as required by applicable law. Any authorization resulting from wrongful, fraudulent or negligent actions of Provider or a breach of this Agreement shall be null and void as of the time given.

2.5 Provider's Standard of Care. Nothing in this Agreement, the Provider Manual, the Benefit Plan, or the Protocols, including without limitation, UBH's utilization management and quality assurance and improvement standards and procedures, shall dictate MHSA Services provided by Provider or otherwise diminish Provider's obligation to freely communicate with and/or provide MHSA Services to Members in accordance with the applicable standard of care.

2.6 Continuity of Care; Referral to Other Health Professionals. Provider shall furnish Covered Services in a manner providing continuity of care and ready referral of

Members to other Participating Providers at times as may be appropriate and consistent with the standards of care in the community. If a Member requires additional services or evaluation, including Emergency Services, Provider agrees to refer Member to his/her primary care physician or another Participating Provider in accordance with the terms and conditions of Member's Benefit Plan. A Member requiring Emergency Services shall also be referred to the "9-1-1" emergency response system.

2.7 Member Access to Care. Provider shall ensure that Members have timely and reasonable access to MHSA Services and shall at all times be reasonably available to Members as is appropriate. If Provider is unavailable when Members call, instructions must be provided for the Member referring the Member to another Participating Provider or to his/her Benefit Plan. Provider shall arrange for an answering machine or service that shall provide the office hours and emergency information and be capable of receiving messages 24 hours a day.

2.8 Employees and Contractors of Provider. Provider will be responsible for and shall ensure that all of its employees and contractors are bound by, and meet the terms and conditions of, this Agreement, the Provider Manual and Protocols, at the time of providing Covered Services to Members. Failure of such employees or contractors to meet such terms and conditions, including without limitation, credentialing requirements, UBH may restrict them from providing Covered Services to Members.

All payments obligated by Payor shall be paid to Provider and Provider will be solely responsible for payments to its employees and contractors who may have provided MHSA Services. Provider agrees to defend, indemnify and hold UBH harmless for any claims, damages, actions, or judgments arising from any employee or contractor of Provider related to the provision of MHSA Services to Members.

ARTICLE 3
Payment Provisions

3.1 Payment for Covered Services. In accordance with the terms and conditions hereof, Payor shall pay Provider for Covered Services provided to a Member by Provider. Payment shall be the lesser of: (a) Provider's Customary Charge, less any applicable Member Expenses; or (b) the Fee Maximum for such MHSA Services, less any applicable Member Expenses.

Subject to the terms and conditions herein, the obligation for payment for Covered Services provided to a Member, less any applicable Member Expenses, is solely that of Payor. Additionally, UBH may arrange for claims processing services. When UBH is the Payor, UBH shall make obligated claim payments to Provider within 45 days (and shall use best efforts to encourage a third-party Payor to make payments within 45 days), or as otherwise required by law, of the date Payor receives all information necessary to process and pay a clean claim, except for claims for which there is coordination of benefits, Member Expense adjustments, disputes about coverage, systems failure or other such causes.

In the event a Member's Benefit Plan provides for a Member Expense whether stated as a flat fee or a percentage, the amount of the Member Expense shall be calculated in accordance with the Member's Benefit Plan or as determined by the Payor. The amount calculated pursuant to the preceding sentence shall be deducted from the amount Provider is to be paid for the Covered Services pursuant to this Agreement.

3.2 Submission of Claims. Provider shall submit claims for MHSA Services to UBH in a manner and format prescribed by UBH, whether in Protocols or otherwise, and which may be in an electronic format. All information necessary to process the claims must be received by UBH no more than 90 days from the date the MHSA Services are rendered. Provider agrees that claims received after this time period may be rejected for payment, at UBH's and/or Payor's sole discretion.

Unless otherwise directed by UBH, Provider shall submit claims using current CMS (HCFA) 1500 or UB04 forms, whichever is appropriate, with applicable coding including, but not limited to, ICD9, CPT, Revenue and HCPCS coding. Provider shall include in a claim the Member number, Customary Charges for the MHSA Services rendered to a Member during a single instance of service, Provider's Federal Tax I.D. number and/or other identifiers requested by UBH.

Payor shall have the right to make, and Provider shall have the right to request, corrective adjustments to a previous payment; provided however, that Payor shall have no obligation to pay additional amounts after 12 months from the date the initial claim was paid.

3.3 Payment in Full. Provider shall accept as payment in full for Covered Services rendered to Members such amounts as are paid by Payor pursuant to this Agreement and shall not bill Members for non-covered charges, other than Member Expenses, which result from Payor's reimbursement methodologies. In no event shall Provider bill a Member for the difference between Customary Charges and the amount Provider has agreed to accept as full reimbursement under this Agreement. Provider may collect Member Expenses from the Member. If Payor denies payment for services rendered by Provider on grounds that the services are not Medically Necessary, Provider shall not collect payment from the Member for the services unless the Member has knowledge of the determination of lack of Medical Necessity and has subsequently agreed in writing to be responsible for such charges and MHSA Services. Further, if any payment to Provider is denied, in part or full, due to Provider's failure to strictly comply with any term or condition in this Agreement, the Provider Manual, the Protocols, including without limitation, obtaining prior authorization, untimely filing of a claim, inaccurate or incorrect submission of or claim processing, or the insolvency of Payor pursuant to applicable law, it is agreed that Provider shall not, except for applicable Member Expenses, bill the Member or otherwise, directly or indirectly, seek or collect payment from the Member for any of the denied amounts. Any violation hereof by Provider shall be deemed a material breach. This provision shall apply regardless of whether any waiver or other document of any kind purporting to allow Provider to collect payment from the Member exists. These provisions shall survive the termination hereof and shall be construed to be for the benefit of the Member.

3.4 Coordination of Benefits. Provider shall be paid in accordance with Payor's coordination of benefits rules.

3.5 Financial Responsibility. In the event of a default (meaning a systematic failure by Payor to fund undisputed claim payments for Covered Services) by a Payor, except when due to the insolvency of Payor, UBH shall notify Provider in writing of such default following UBH's determination thereof. Any services which have been rendered by Provider prior to or after such notification, and which have not been paid for by Payor, shall be considered ineligible for reimbursement under this Agreement, and Provider may seek payment directly from the Payor and Member for such services.

3.6 Member Protection Provision. This provision supersedes and replaces the Financial Responsibility section (section 3.5 above) only in those cases where UBH, or its Affiliate, is the Payor, or when required by another specific Payor, or when required pursuant to applicable laws, statutes and regulations.

In no event, including, but not limited to, non-payment by Payor for MHSA Services rendered to Members by Provider, insolvency of Payor, or breach by UBH of any term or condition of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Member or persons acting on behalf of the Member for MHSA Services eligible for reimbursement under this Agreement; provided, however, that Provider may collect from the Member, any Member Expenses or charges for services that are not covered as benefits under the Member's Benefit Plan.

The provisions of this Article shall apply to all Member protection provisions in this Agreement and shall: (a) apply to all MHSA Services rendered while this Agreement is in force; (b) survive the termination of this Agreement regardless of the cause of termination; (c) be construed to be for the benefit of the Members; and (d) except as otherwise stated in section 3.3, supersede any oral or written agreement, existing or subsequently entered into, between Provider and a Member or person acting on a Member's behalf, that requires the Member to pay for such MHSA Services.

3.7 Contracted Rate for Members. Provider agrees to continue to provide MHSA Services to Members who have exhausted his/her Covered Services under the Benefit Plan and agrees not to collect or charge more than the contracted rate for those MHSA Services. Provider may bill the Member directly for those MHSA Services for which there is no longer any coverage under the Benefit Plan, in accordance herewith.

ARTICLE 4
Laws, Regulations, and Licenses, and Liabilities of Parties

4.1 Laws, Regulations and Licenses. Provider shall maintain in good standing all federal, state and local licenses, certifications and permits -- without sanction, revocations, suspension, censure, probation or material restriction -- which are required to provide health care services according to the laws of the jurisdiction in which MHSA Services are provided, and shall comply with all applicable statutes and regulations.

Provider shall also require that all health care professionals employed by or under contract with Provider to render MHSA Services to Members, including covering Providers, comply with this provision.

4.2 Responsibility for Damages. Any and all damages, claims, liabilities or judgments, attorney fees, which may arise as a result of Provider's or its employee's or contractor's negligence or intentional wrongdoing shall be the sole responsibility of Provider.

4.3 Provider Liability Insurance. Provider shall procure and maintain, at Provider's sole expense, (a) medical malpractice or professional liability insurance in the amount of $1,000,000 per occurrence and $3,000,000 in aggregate if Provider is a Medical Doctor and $1,000,000 per occurrence and in aggregate if Provider is not a Medical Doctor; and (b) comprehensive general and/or umbrella liability insurance in the amount of $1,000,000 per occurrence and in aggregate. Provider shall also require that all health care professionals employed by or under contract with Provider to render MHSA Services to Members procure and maintain malpractice insurance, unless they are covered under Provider's insurance policies.

Provider's and other health care professionals' medical malpractice insurance shall be on either an "occurrence" or "claims made" basis provided that for a "claims made" policy, such policy must be written with an extended period reporting option under such terms and conditions as may be reasonably required by UBH. Prior to the Effective Date of this Agreement and at each policy renewal thereafter, Provider shall submit to UBH in writing evidence of insurance coverage.

ARTICLE 5
Notices

5.1 Notices. Provider shall notify UBH within ten (10) days of knowledge of any of the following:

(a) changes in liability insurance carriers, termination of, renewal of or any other material changes in Provider's liability insurance, including reduction of limits, erosion of aggregate, changes in retention or non-payment of premium;
(b) action which may result in or the actual suspension, sanction, revocation, condition, limitation, qualification or other material restriction on Provider's licenses, certifications or permits by any government under which Provider is authorized to provide health care services; and, of any suspension, revocation, condition, limitation, qualification or other material restriction of Provider's staff privileges at any licensed hospital, nursing home or other facility at which Provider has staff privileges during the term of this Agreement;
(c) a change in Provider's name, address, ownership or Federal Tax I.D. number;
(d) indictment, arrest or conviction for a felony or for any criminal charge related to the practice of Provider's profession;
(e) claims or legal actions for professional negligence or bankruptcy;

(f) provider's termination, for cause, from any other provider network offered by any plan, including, without limitation, any health care service plan, health maintenance organization, any health insurer, any preferred provider organization, any employer or any trust fund;
(g) any occurrence or condition that might materially impair the ability of Provider to perform its duties under this Agreement; or
(h) any condition or circumstance that may pose a direct threat to the safety of Provider, Providers' staff, or Members.

Unless otherwise specified in this Agreement, each and every notice and communication to the other party shall be in writing. All written notices or communication shall be deemed to have been given when delivered in person; or, on the date mailed, if delivered by first-class mail, proper postage prepaid and properly addressed to the appropriate party at the address set forth at the signature portion of this Agreement or to another address of which sending party has been notified, including without limitation, to UBH's Network Manager at the applicable address for notice as identified in the Provider Manual or Protocols. The parties shall, by written notice, provide and update each other with the most current address and names of all parties or designees that should receive certain notices or communication.

ARTICLE 6
Records

6.1 Confidentiality of Records. UBH and Provider shall maintain the confidentiality of all Member information and records in accordance with all applicable state and federal laws, statutes and regulations, including without limitation, the Health Insurance Portability and Accountability Act.

6.2 Maintenance of and UBH Access to Records. Provider shall maintain adequate medical, treatment, financial and administrative records related to MHSA Services provided by Provider under this Agreement for a period and in a manner consistent with the standards of the community and in accordance with the Provider Manual, Protocols and all applicable state and federal laws, statutes and regulations.

In order to perform its utilization management and quality improvement activities, UBH shall have access to such information and records, including claim records, within 14 days from the date the request is made, except that in the case of an audit by UBH, such access shall be given at the time of the audit. If requested by UBH, Provider shall provide copies of such records free of charge. During the term of this Agreement UBH shall have access to and the right to audit information and records to the extent permitted by the Provider Manual, or as otherwise required by state or federal laws, statutes or regulations or regulatory authority. Said rights shall continue following the termination hereof for the longer of three years or for such period as may be permitted by applicable state or federal law, regulatory authority, or Protocols.

It is Provider's responsibility to obtain any Member's consent in order to provide UBH with requested information and records or copies of records and to allow UBH to

release such information or records to Payors as necessary for the administration of the Benefit Plan or compliance with any state or federal laws, statutes and regulations applicable to the Payors.

Provider acknowledges that in receiving, storing, processing or otherwise dealing with information from UBH or Payor about Members, it is fully bound by the provisions of the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2; and Provider agrees that it will resist in judicial proceedings any effort to obtain access to information pertaining to patients otherwise than as expressly provided for in the federal confidentiality regulations, 42 CFR Part 2.

This section shall not be construed to grant UBH access to Provider's records that are created for purposes of assessing Provider's financial performance or for Provider's peer review activities, except to the extent the federal and/or state government and any of their authorized representatives have access to such records pursuant to Section 6.3.

6.3 Government and Accrediting Agency Access to Records. It is agreed that the federal, state and local government, or accrediting agencies including, but not limited to, the National Committee for Quality Assurance (the "NCQA"), and any of their authorized representatives, shall have access to, and UBH and Provider are authorized to release, in accordance with applicable statutes and regulations, all information and records or copies of such, within the possession of UBH or Provider, which are pertinent to and involve transactions related to this Agreement if such access is necessary to comply with accreditation standards, statutes or regulations applicable to UBH, Payor or Provider. Such access shall be available and provided during the term of this Agreement and for three years following the termination hereof, or such longer period as may be identified in the Provider Manual or Protocols or as required by applicable state or federal laws, statutes or regulations.

ARTICLE 7
Resolution of Disputes

7.1 Resolution of Disputes. It is agreed that prior to any other remedy available to the parties, UBH, Payor and/or Provider shall provide written notice of any disputes or claims arising out of their business relationship (the “Dispute”) to the other party within thirty (30) days of the final decision date, action, omission or cause from which the Dispute arose, whichever is later (the “Dispute Date”). If the Dispute pertains to a matter which is generally administered by certain UBH procedures, such as a credentialing or quality improvement plan, the procedures set forth in that plan must be fully exhausted by Provider before Provider may invoke his or her rights as described herein. After receipt of the written notice of the Dispute, the parties agree to work together in good faith to resolve the Dispute. If the parties are unable to resolve the Dispute within thirty (30) days following receipt of the notice of the Dispute, and if either UBH, Provider or Payor desires to pursue formal resolution of the Dispute, then said party shall issue a notice of arbitration to the other parties. It is agreed that the parties

knowingly and voluntarily waive any right to a Dispute if arbitration is not initiated within one year after the Dispute Date.

Any arbitration proceeding under this Agreement shall be submitted to binding arbitration in accordance with the rules of the American Arbitration Association ("AAA"), and shall be conducted in a location agreed to by the parties or as selected by the AAA if the parties cannot agree on a location. The arbitrators may construe or interpret but shall not vary or ignore the terms of this Agreement, shall have no authority to award any punitive or exemplary damages, and shall be bound by controlling law. The parties acknowledge that because this Agreement affects interstate commerce the Federal Arbitration Act applies.

ARTICLE 8
Term and Termination

8.1 Term. This Agreement shall begin on the Effective Date and it shall remain in effect for one year, and shall automatically renew for successive 1-year terms until it is terminated in accordance with the provisions herein.

8.2 Termination. This Agreement may be terminated as follows:

(a) by mutual agreement of UBH and Provider;
(b) by either party upon 90 days prior written notice to the other party;
(c) by either party, in the event of a material breach of this Agreement by the other party, upon 30 days prior written notice to the other party. The written notice shall specify the precise nature of the breach. In the event the breaching party cures the breach to the reasonable satisfaction of the non-breaching party, within 30 days after the non-breaching party's written notice, this Agreement shall not terminate;
(d) by UBH immediately upon written notice to Provider, due to Provider's loss, suspension, restriction, probation, voluntary relinquishment, or any other adverse action taken against any of Provider's licenses or certification, or loss of insurance required under this Agreement;
(e) by Provider upon 60 days prior written notice to UBH due to a unilateral amendment made to this Agreement pursuant to section 9.1;
(f) by UBH in accordance with its credentialing plan;
(g) by UBH immediately if UBH determines, in its sole discretion, that the health, safety or welfare of Members may be jeopardized by the continuation of this Agreement; or
(h) by UBH in accordance with the Provider Manual or Protocols.

During periods of notice of termination, UBH reserves the right to transfer Members to another Participating Provider, and Provider agrees to cooperate and assist with such transfers.

If Provider is terminated through the UBH credentialing or recredentialing process, this Agreement shall be deemed terminated as of the date Provider has been terminated pursuant to a final action resulting from that process.

8.3 Information to Members. Provider acknowledges and agrees that UBH has the right to inform Members of Provider's termination and/or the notice of termination to Provider, and agrees to cooperate with UBH in matters concerning the termination/transition, and agrees to hold UBH harmless for exercising its rights hereunder. Provider also agrees to clearly inform Members of Provider's impending non-participation status upon the earlier of Member's next appointment or prior to the effective termination date.

8.4 Continuation of Services After Termination. At the option of UBH, Provider shall continue to provide MHSA Services authorized by UBH to Members who are receiving such services from Provider as of the effective date of termination of this Agreement, until Member can be satisfactorily transferred to another Participating Provider. Payor shall continue to pay Provider for such services at Provider's contracted rate.

ARTICLE 9
Miscellaneous

9.1 Amendment. UBH may amend this Agreement by sending notice of the amendment to Provider at least 30 days prior to its effective date. The Provider's signature is not required. It is agreed that this Agreement shall be automatically amended to comply with any and all applicable state or federal laws, regulations, statutes or the requirements of applicable regulatory authorities as of the effective date thereof, and which shall be deemed to be incorporated herein by reference as of its effective date. Likewise, if a Payor that is a governmental entity requires that certain provisions of this Agreement be removed, replaced, amended or that additional provisions be incorporated, such provisions shall be deemed to be removed, replaced, amended or additional provisions incorporated into this Agreement as of the effective date of such Payor requirement for all MHSA Services provided which are subject to such Payor requirements without the signature of Provider being required.

9.2 Assignment. UBH may assign all or any of its rights and responsibilities under this Agreement to any of its Affiliates. Provider may assign any of his or her rights and responsibilities under this Agreement to any person or entity only upon the prior written consent of UBH, which consent shall not be unreasonably withheld.

9.3 Administrative Responsibilities. UBH may delegate certain administrative responsibilities under this Agreement to another entity, including, but not limited to, its Affiliate or to Payor or its designee. In addition, certain Payor responsibilities may actually be performed by its designee.

9.4 Relationship Between UBH and Provider. The relationship between UBH and Provider is solely that of independent contractors and nothing in this Agreement or

otherwise shall be construed or deemed to create any other relationship, including one of employment, agency, joint venture or partnership.

9.5 Name, Symbol and Service Mark. During the term of this Agreement, Provider, UBH and Payor shall have the right to use each other's name solely to make public reference to Provider as a Participating Provider. Provider, UBH and Payor shall not otherwise use each other's name, symbol or service mark or that of their Affiliates without the prior written approval from the appropriate party.

9.6 Confidentiality. Neither party shall disclose to third parties any confidential or proprietary business information which it receives from the other party, including, but not limited to, financial statements, business plans, Protocols and programs; except that (a) Provider may disclose information to a Member relating to the Member's treatment plan and the payment methodology, but not specific rates; (b) UBH may disclose certain terms to Payors or designees that need the information to process claims or administer a Benefit Plan, and may file the form of this Agreement with any federal or state regulatory entity as may be required by applicable law; and (c) UBH shall be permitted to disclose, in its sole discretion, any other data or information that may be requested by applicable state and federal law, state regulations or governing agencies that pertain to this Agreement or that may relate to the enforcement of any right granted or term or condition of this Agreement.

9.7 Communication. UBH encourages Provider to discuss with Members treatment options and their associated risks and benefits, regardless of whether the treatment is covered under the Member's Benefit Plan. Nothing in this Agreement is intended to interfere with Provider's relationship with Members as patients of Provider, or with UBH's ability to administer its quality improvement, utilization management and credentialing programs.

9.8 Effects of New Statutes and Regulations and Changes of Conditions. The parties agree to re-negotiate this Agreement if either party would be materially adversely affected by continued performance as a result of a change in laws or regulations, a requirement that one party comply with an existing law or regulation contrary to the other party's prior reasonable understanding, or a change in UBH's arrangements with Payors. The party affected must promptly notify the other party of the change or required compliance and its desire to re-negotiate this Agreement. If a new agreement is not executed within 30 days of receipt of the re-negotiation notice, the party adversely affected shall have the right to terminate this Agreement upon 45 days prior written notice to the other party. Any such notice of termination must be given within 10 days following the expiration of the 30-day re-negotiation period.

9.9 Appendices. Additional and/or alternative provisions, if any, related to certain MHSA Services rendered by Provider to Members covered by certain Benefit Plans are set for in the Appendices.

9.10 Entire Agreement. On the Effective Date, this Agreement supersedes and replaces any existing Provider Agreements between the parties related to the provision

of MHSA Services, including any agreements between Provider and Affiliates of UBH for MHSA Services. This Agreement, together with any and all documents referenced herein, attachments, addenda, appendices, as may be amended or modified from time to time, whether contemporaneous or subsequently made pursuant to Section 9.1, are hereby incorporated herein by reference, and constitutes the entire agreement between the parties in regard to its subject matter (herein collectively referred to as this "Agreement").

9.11 Strict Compliance. The waiver of strict compliance or performance of any of the terms or conditions of this Agreement, the Provider Manual or the Protocols or of any breach thereof shall not be held or deemed to be a waiver of any subsequent failure to comply strictly with or perform the same or any other term or condition thereof or any breach thereof.

9.12 Severability. Should any provision of this Agreement violate the law or be held invalid or unenforceable as written by a court of competent jurisdiction, then said provision along with the remainder of this Agreement shall nonetheless be enforceable to the extent allowable under applicable law by first modifying said provision to the extent permitted so as to comply with applicable law; otherwise said provision shall be deemed void to the extent of such prohibition without invalidating the remainder of this Agreement.

9.13 Rules of Construction. In the event of any conflict between the terms of this Agreement and the terms of any other agreement or any other controlling document or any applicable state or federal laws, statutes and regulations relating to the subject matter hereof, the terms, except as otherwise expressly stated herein, shall first be read together to the extent possible; otherwise the terms that afford the greater protections to first UBH and second to the Benefit Plan shall prevail over the conflicting term, to the extent permitted by, in accordance with and subject to applicable law, statutes or regulations. The remainder of the Agreement shall otherwise remain without invalidating or deleting the remainder of the conflicting provision or the Agreement.

9.14 Governing Law. This Agreement shall be governed by and construed in accordance with applicable state and federal laws, statutes and regulations, including without limitation, ERISA.

9.15 Medicaid Members. If a Medicaid Appendix is attached to this Agreement Provider agrees to provide MHSA Services to Members enrolled in a Benefit Plan for Medicaid recipients and to comply with any additional requirements set forth in the Medicaid Appendix.

9.16 Medicare Members. If a Medicare Appendix is attached to this Agreement, Provider agrees to provide MHSA Services under this Agreement, to Members who are enrolled in a Benefit Plan for Medicare beneficiaries and to cooperate and comply with the provisions set forth in the attached Medicare Advantage Addendum. Provider also understands that UBH's agreements with Participating Providers are subject to review and approval by the Centers for Medicare and Medicaid Services (“CMS”).

9.17 Survival. Upon any termination or expiration of this Agreement, the provisions herein which contemplates performance or observance subsequent to termination or expiration, including without limitation, sections 3.1, 3.2, 3.3, 3.6, 8.3, 8.4, 9.6 and Articles 6 and 7, shall survive and remain of full force and effect between the parties.

THIS AGREEMENT CONTAINS A BINDING ARBITRATION PROVISION THAT MAY BE ENFORCED BY THE PARTIES.

NAME OF PROVIDER

_____

_____

Attn: _____

Signature_____

Print Name_____

Title_____

Date_____

Federal Tax ID Number: _____

Medicare Number:_____

Medicaid Number:_____

NPI Number: _____

UNITED BEHAVIORAL HEALTH
PROVIDER AGREEMENT

Kansas Regulatory Requirements Attachment

This **Kansas** Regulatory Requirements Attachment (the "Attachment") is made part of this Agreement entered into between United Behavioral Health ("UBH") and the health care professional named in this Agreement ("Provider").

This Attachment applies to all products or Benefit Plans sponsored, issued or administered by or accessed through UBH to the extent such products are regulated under **Kansas** laws.

UBH and Provider each agree to be bound by the terms and conditions contained in this Attachment. In the event of a conflict or inconsistency between this Attachment and any term or condition contained in this Agreement, this Attachment shall control, except with regard to Benefit Plans outside the scope of this Attachment, and be read in accordance with applicable laws and regulations.

Except as otherwise defined in this Attachment, all terms contained in the Attachment shall be as defined and set forth in the Agreement. Any undefined term herein shall have the meaning as defined in applicable state laws or regulations, as may be amended from time to time. Likewise, should any defined term herein conflict with applicable state law or regulation, the term as defined under applicable state law or regulation shall prevail.

Provisions to Benefit Plans regulated by the State of Kansas and/or under Kansas HMO laws, as applicable.

1. **Confidentiality of Medical Information.** Any data or information pertaining to the diagnosis, treatment or health of any Member obtained from the Member or from any provider shall be held in confidence and shall not be disclosed to any person except to the extent that it may be necessary pursuant to applicable federal or state law or upon the express consent of the Member or any Provider. In no case shall the name of a Member be disclosed in any data pertaining to the diagnosis, treatment or health of such Member in any medical review procedure or in any report required under the provisions of the Kansas Health Maintenance Organization Act (or the rules and regulations issued pursuant thereto) unless such Member has expressly consented thereto. UBH shall be entitled to claim any statutory privileges against such disclosure that the Provider who furnished such information to UBH is entitled to claim.

   Upon the express request of the Member, a complete record of any data or information pertaining to the diagnosis, treatment or health of such Member obtained from the Member or from the Provider by UBH shall be provided to another health care provider designated by the Member when such Member is no longer a Covered Member.

2. **Continuity of Care.** If this Agreement between UBH and Provider is terminated or Provider is terminated from participation, Provider shall continue to provide care to a Member for a period of up to ninety (90) days in those cases where the continuation of such care is medically necessary and in accordance with the standard of MHSA Health Services and where the Member has applicable special circumstances. The Member shall not be liable to Provider for any amounts owed for services other than any of the Member's expenses (deductibles or copayment amounts specified in the health benefit plan or other contract between the Member and Plan). If Provider is authorized to continue treating a Member pursuant to this section, Payor shall pay Provider at the previously contracted rate for services provided to the Member.

3. **Medicaid Payment Source of Last Resort**. If valid Medicaid coverage provides benefits for the same loss or condition covered by UBH or Payer pursuant to this Agreement, Provider acknowledges that Medicaid coverage shall be the source of last resort of any payment to Provider.

4. **Method for Resolving Member Grievances**. Provider has received a clear and understandable description of UBH's method for resolving Member grievances. Provider agrees to comply with such grievance process as applicable.

5. **Audit**. Provider agrees that the Commissioner of Insurance of the State of Kansas has the right to examine the affairs of Provider related to services provided to Payors regulated by the State of Kansas pursuant to Kansas Statutes Section 40-3211.

6. **Emergency Medical Services.**

   (a) **Member Responsibility**. If Provider is responsible for seeking prior authorization from UBH or Payor before receiving payment for treatment of emergency medical conditions and a Member is eligible at the time when Covered Services are provided, then the Member shall not be held financially responsible for payment of Covered Services, other than any copayments, coinsurance or deductibles for which Member is responsible under the terms of the Member's Benefit Plan, if the prior authorization for emergency medical services has not been sought or received.

   (b) **Coverage/Prior Authorization**. UBH or Payor shall not deny coverage for emergency services if the symptoms presented by the Member and recorded by Provider indicate that an emergency medical condition exists, or for emergency services necessary to provide a Member with a medical examination and stabilizing treatment, regardless of whether prior authorization was obtained to provide those services. If UBH or Payor authorizes emergency services, UBH or Payor will not subsequently rescind or modify that authorization after provider renders the authorized care in good faith and pursuant to the authorization except for: (i) payments made as a result of misrepresentation, fraud,

omission or clerical error; and (ii) copayment, coinsurance or deductible amounts that are the responsibility of the Member. Once the Member is stabilized, UBH or Payor may require prior authorization as a condition of further coverage for continuing treatment, specialty consultations, transfer arrangements or other medically necessary and appropriate care for the Member. For required post evaluation or post stabilization services immediately following treatment of an emergency medical condition, UBH or Payor shall provide access to an authorized representative 24 hours a day, seven days a week, if UBH or Payor require authorization for such services.

7. **Prompt Pay.** UBH or Payor, as applicable, will pay claims as required by Kansas Statutes Section 40-2442 as may be amended from time to time.

MEDICARE ADVANTAGE REGULATORY REQUIREMENTS APPENDIX
UNITED BEHAVIORAL HEALTH
PROVIDER

THIS MEDICARE ADVANTAGE REGULATORY REQUIREMENTS APPENDIX (this "Appendix") supplements and is made part of the provider agreement (the "Agreement") between UNITED BEHAVIORAL HEALTH ("UBH"), it subsidiaries, and its affiliated companies (collectively, "Company") and the provider named in the Agreement ("Provider").

SECTION 1
APPLICABILITY

This Appendix applies to the Covered Services Provider provides to Medicare Advantage Customers. 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: (1) with regard to Benefit Plans outside the scope of this Appendix; or (2) as required by applicable law.

SECTION 2
DEFINITIONS

For purposes of this Appendix, the following terms shall have the meanings set forth below.

2.1 **Benefit Plan:** A certificate of coverage, summary plan description, or other document or agreement, whether delivered in paper, electronic, or other format, under which a Payer is obligated to provide coverage of Covered Services for a Customer.

2.2 **CMS Contract:** A contract between the Centers for Medicare & Medicaid Services ("CMS") and a Medicare Advantage Organization for the provision of Medicare benefits pursuant to the Medicare Advantage Program under Title XVIII, Part C of the Social Security Act.

2.3 **Cost Sharing:** Those costs, if any, under a Benefit Plan that are the responsibility of the Customer, including deductibles, coinsurance, and copayments.

2.4 **Covered Service:** A health care service or product for which a Customer is entitled to receive coverage from a Payer, pursuant to the terms of the Customer's Benefit Plan with that Payer.

2.5 **Customer:** A person eligible and enrolled to receive coverage from a Payer for Covered Services.

2.6 **Dual Eligible Customer:** A Medicare Advantage Customer who is: (a) eligible for Medicaid; and (b) for whom the state is responsible for paying Medicare Part A and B Cost Sharing.

2.7 **Medicare Advantage Benefit Plans:** Benefit Plans sponsored, issued or administered by a Medicare Advantage Organization as part of the Medicare Advantage program or as part of the Medicare Advantage program together with the Prescription Drug program under Title XVIII, Part C and Part D, respectively, of the Social Security Act (as those program names may change from time to time).

2.8 **Medicare Advantage Customer or MA Customer:** A Customer eligible for and enrolled in a Medicare Advantage Benefit Plan in which Provider participates pursuant to the Agreement.

2.9 **Medicare Advantage Organization or MA Organization:** For purposes of this Appendix, MA Organization is an appropriately licensed entity that has entered into: (a) a CMS Contract; and (b) a contract with Company, either directly or indirectly, under which Company provides certain administrative services for Benefit Plans sponsored, issued, or administered by MA Organization.

2.10 **Payer:** An entity obligated to a Customer to provide reimbursement for Covered Services under the Customer's Benefit Plan, and authorized to access Provider's services under the Agreement.

SECTION 3
PROVIDER REQUIREMENTS

3.1 **Data.** Provider shall submit to Company or MA Organization, as applicable, all risk adjustment data as defined in 42 CFR 422.310(a), and other Medicare Advantage program-related information as may be requested by MA Organization, within the timeframes specified and in a form that meets Medicare Advantage program requirements. By submitting data to Company or MA Organization, Provider represents to MA Organization, and upon MA Organization's request Provider shall certify in writing, that the data is accurate, complete, and truthful, based on Provider's best knowledge, information and belief.

3.2 **Policies.** Provider shall cooperate and comply with MA Organization's policies and procedures.

3.3 **Customer Protection.** Provider agrees that in no event, including but not limited to, non-payment by Company, MA Organization or an intermediary, insolvency of Company, MA Organization or an intermediary, or breach by Company of the Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any MA Customer or person (other than MA Organization or an intermediary) acting on behalf of the MA Customer for Covered Services provided pursuant to the Agreement or for any other fees that are the legal obligation of MA Organization under the CMS Contract. This provision does not prohibit Provider from collecting from MA Customers allowable Cost Sharing. This provision also does not prohibit Provider and an MA Customer from agreeing to the provision of services solely at the expense of the MA Customer, as long as Provider has clearly informed the MA Customer, in accordance with applicable law, that the MA Customer's Benefit Plan may not cover or continue to cover a specific service or services.

In the event of MA Organization's, Company, or an intermediary's insolvency or other cessation of operations or termination of MA Organization's contract with CMS, Provider shall continue to provide Covered Services to an MA Customer through the later of the period for which premium has been paid to MA Organization on behalf of the MA Customer, or, in the case of MA Customers who are hospitalized as of such period or date, the MA Customer's discharge.

This provision shall be construed in favor of the MA Customer, shall survive the termination of the Agreement regardless of the reason for termination, including Company or MA Organization's insolvency, and shall supersede any contrary agreement, oral or written, between Provider and an MA Customer or the representative of an MA Customer if the contrary agreement is inconsistent with this provision.

For the purpose of this provision, an "intermediary" is a person or entity authorized to negotiate and execute the Agreement on behalf of Provider or on behalf of a network through which Provider elects to participate.

3.4 **Dual Eligible Customers.** Provider agrees that in no event, including but not limited to, non-payment by a State Medicaid Agency or other applicable regulatory authority, other state source, or breach by Company of the Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Dual Eligible Customer, person acting on behalf of the Dual Eligible Customer, Company or MA Organization (unless notified otherwise) for Medicare Part A and B Cost Sharing. Instead, Provider will either: (a) accept payment made by or on behalf of MA Organization as payment in full; or (b) bill the appropriate state source for such Cost Sharing amount. If Provider imposes an excess charge on a Dual Eligible Customer, Provider is subject to any lawful sanction that may be imposed under Medicare or Medicaid. This provision does not prohibit Provider and a Dual Eligible Customer from agreeing to the provision of services solely at the expense of the Dual Eligible Customer, as long as Provider has clearly informed the Dual Eligible Customer, in accordance with applicable law, that the Dual Eligible Customer's Benefit Plan may not cover or continue to cover a specific service or services.

3.5 **Eligibility.** Provider agrees to immediately notify Company and MA Organization in the event Provider is or becomes excluded from participation in any federal or state health care program under Section 1128 or 1128A of the Social Security Act. Provider also shall not employ or contract for the provision of health care services, utilization review, medical social work or administrative services, with or without compensation, with any individual or entity that is or becomes excluded from participation in any federal or state health care program under Section 1128 or 1128A of the Social Security Act.

3.6 **Laws.** Provider shall comply with all applicable federal and Medicare laws, regulations, and CMS instructions, including but not limited to: (a) federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including but not limited to, applicable provisions of federal criminal law, the False Claims Act (31 U.S.C. §3729 et seq.), and the anti-kickback statute (§1128B of the Social Security Act); and (b) HIPAA administrative simplification rules at 45 CFR Parts 160, 162, and 164.

3.7 **Federal Funds.** Provider acknowledges and agrees that MA Organization receives federal payments under the CMS Contract and that payments Provider receives from or on behalf of MA Organization are, in whole or in part, from federal funds. Provider is therefore subject to certain laws that are applicable to individuals and entities receiving federal funds.

3.8 **CMS Contract**. Provider shall perform the services set forth in the Agreement in a manner consistent with and in compliance with MA Organization's contractual obligations under the CMS Contract.

3.9 **Records.**

(a) Maintenance; Privacy and Confidentiality; Customer Access. Provider shall maintain records and information related to the services provided under the Agreement, including but not limited to MA Customer medical records and other health and enrollment information, in an accurate and timely manner. Provider shall maintain such records for the longer of the following periods:

(i) in the case of records containing information related to the medical loss ratio information reported to CMS by the MA Organization, including, for example, information related to incurred claims and quality improvement activities, at least ten (10) years from the date such medical loss ratio information is reported to CMS by the MA Organization, or

(ii) in the case of all records, at least ten (10) years from the final date of the CMS Contract period in effect at the time the records were created, or such longer period as required by law.

Provider shall safeguard MA Customer privacy and confidentiality, including but not limited to the privacy and confidentiality of any information that identifies a particular MA Customer, and shall comply with all federal and state laws regarding confidentiality and disclosure of medical records or other health and enrollment information. Provider shall ensure that MA Customers have timely access to medical records and information that pertain to them, in accordance with applicable law.

(b) Government Access to Records. Provider acknowledges and agrees that the Secretary of Health and Human Services, the Comptroller General, or their designees shall have the right to audit, evaluate and inspect any pertinent books, contracts, computer or other electronic systems (including medical records), patient care documentation and other records and information belonging to Provider that involve transactions related to the CMS Contract. This right shall extend through the longer of the following periods:

(i) in the case of records containing information related to the medical loss ratio information reported to CMS by the MA Organization, including, for example, information related to incurred claims and quality improvement

activities, at least ten (10) years from the date such medical loss ratio information is reported to CMS by the MA Organization, or

(ii) in the case of all records, at least ten (10) years from the later of the final date of the CMS Contract period in effect at the time the records were created or the date of completion of any audit, or longer in certain instances described in the applicable Medicare Advantage regulations.

For the purpose of conducting the above activities, Provider shall make available its premises, physical facilities and equipment, records relating to MA Customers, and any additional relevant information CMS may require.

(c) MA Organization Access to Records. Provider shall grant MA Organization or its designees such audit, evaluation, and inspection rights identified in subsection 3.9(b) as are necessary for MA Organization to comply with its obligations under the CMS Contract. Whenever possible, MA Organization will give Provider reasonable notice of the need for such audit, evaluation or inspection, and will conduct such audit, evaluation or inspection at a reasonable time and place. Provider shall submit medical records of MA Customers to the MA Organization as may be requested, within the timeframes specified, for the purpose of (i) CMS audits of risk adjustment data and (ii) for other purposes medical records from providers are used by MA Organization, as specified by CMS. Provision of medical records must be in the manner consistent with HIPAA privacy statute and regulations.

3.10 **MA Organization Accountability; Delegated Activities.** Provider acknowledges and agrees that MA Organization oversees and is accountable to CMS for any functions and responsibilities described in the CMS Contract and applicable Medicare Advantage regulations, including those that Company may sub-delegate to Provider. If Company has sub-delegated any of MA Organization's functions and responsibilities under the CMS Contract to Provider pursuant to the Agreement, the following shall apply in addition to the other provisions of this Appendix:

(a) Provider shall perform those delegated activities specified in the Agreement, if any, and shall comply with any reporting responsibilities as set forth in the Agreement.

(b) If Company has delegated to Provider any activities related to the credentialing of health care providers, Provider must comply with all applicable CMS requirements for credentialing, including but not limited to the requirement that the credentials of medical professionals must either be reviewed by MA Organization or its designee, or the credentialing process must be reviewed, pre-approved and audited on an ongoing basis by MA Organization or its designee.

(c) If Company has delegated to Provider the selection of health care providers to be participating providers in the MA Organization's Medicare Advantage network, MA Organization retains the right to approve, suspend or terminate the participation status of such health care providers.

(d) Provider acknowledges that MA Organization or its designee shall monitor Provider's performance of any delegated activities on an ongoing basis. If MA Organization or CMS determines that Provider has not performed satisfactorily, MA Organization may revoke any or all delegated activities and reporting requirements. Provider shall cooperate with MA Organization and Company regarding the transition of any delegated activities or reporting requirements that have been revoked by MA Organization.

3.11 **Subcontracts.** If Provider has any arrangements, in accordance with the terms of the Agreement, with affiliates, subsidiaries, or any other subcontractors, directly or through another person or entity, to perform any of the services Provider is obligated to perform under the Agreement that are the subject of this Appendix, Provider shall ensure that all such arrangements are in writing, duly executed, and include all the terms contained in this Appendix. Provider shall provide proof of such to Company or MA Organization upon request. Provider further agrees to promptly amend its agreements with subcontractors, in a manner consistent with the changes made to this Appendix by MA Organization or Company, to meet any additional CMS requirements that may apply to the services.

3.12 **Offshoring.** Unless previously authorized by MA Organization in writing, all services provided pursuant to the Agreement that are subject to this Appendix must be performed within the United States, the District of Columbia, or the United States territories.

SECTION 4
OTHER

4.1 **Payment.** MA Organization or its designee shall promptly process and pay or deny Provider's claim no later than sixty (60) days after MA Organization or its designee receives all appropriate information as described in MA Organization's administrative procedures. If Provider is responsible for making payment to subcontracted providers for services provided to MA Customers, Provider shall pay them no later than sixty (60) days after Provider receives request for payment for those services from subcontracted providers.

4.2 **Regulatory Amendment.** Upon the request of MA Organization, Company may unilaterally amend this Appendix to comply with applicable laws and regulations and the requirements of applicable regulatory authorities, including but not limited to CMS. Company or MA Organization shall provide written or electronic notice to Provider of such amendment and its effective date. 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.

KANSAS MEDICAID AND CHIP

REGULATORY REQUIREMENTS APPENDIX

DOWNSTREAM PROVIDER

THIS KANSAS MEDICAID AND CHIP REGULATORY REQUIREMENTS APPENDIX (this "Appendix") supplements and is made part of the provider agreement (the "Agreement") between United Behavioral Health ("Subcontractor") and the party 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 KanCare, Kansas' Medicaid and/or Children's Health Insurance ("CHIP") program (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. In the event Subcontractor is required to amend or supplement this Appendix as required or requested by Health Plan and the State to comply with federal or State regulations, Subcontractor will unilaterally initiate such additions, deletions or modifications.

SECTION 2
DEFINITIONS

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

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

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

2.4 **Department:** The Kansas Department of Health and Environment – Division of Health Care Finance (KDHE-DHCF). KDHE-DHCF is responsible for administering the State Program.

2.5 **Health Plan:** An appropriately licensed entity that has entered into a contract with Subcontractor, either directly or indirectly, under which Subcontractor provides certain

administrative services for Health Plan pursuant to the State Contract. For purposes of this Appendix, Health Plan refers to UnitedHealthcare of the Midwest, Inc.

2.6 **KanCare:** The Department's prepaid managed care health program for Medicaid-eligible persons and persons enrolled in the State Children's Health Insurance Program.

2.7 **State:** The State of Kansas or its designated regulatory agencies.

2.8 **State Contract:** Health Plan's contract with the Department for the purpose of providing and paying for Covered Services to Covered Persons enrolled in the State Program that requires Health Plan and Subcontractor to meet certain performance standards while doing so.

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

SECTION 3
PROVIDER REQUIREMENTS

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

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

(a) **Clean Claim**: A claim submitted in accordance with 42 C.F.R. 447.45, as amended from time to time, that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a State's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

(b) **Emergency Medical Condition**: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) 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 the following:

(1) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
(2) Serious impairment to bodily functions.
(3) Serious dysfunction of any bodily organ or part.

(c) **Emergency Services: C**overed inpatient and outpatient services that are as follows:
(1) Furnished by a provider that is qualified to furnish these services under this title.
(2) Needed to evaluate or stabilize an emergency medical condition.

(d) **Medically Necessary or Medical Necessity**: As defined in K.A.R. 30-5-58 (ooo), (1) a health intervention that is otherwise a Covered Service, is not specifically excluded from coverage, and is medically necessary, according to all of the following criteria:

(A) "Authority." The health intervention is recommended by the treating physician and is determined to be necessary.

(B) "Purpose." The health intervention has the purpose of treating a medical condition.

(C) "Scope." The health intervention provides the most appropriate supply or level of service, considering potential benefits and harms to the patient.

(D) "Evidence." The health intervention is known to be effective in improving health outcomes. For new interventions, effectiveness shall be determined by scientific evidence as provided in paragraph (3). For existing interventions, effectiveness shall be determined as provided in paragraph (4).

(E) "Value." The health intervention is cost-effective for this condition compared to alternative interventions, including no intervention. "Cost-effective" shall not necessarily be construed to mean lowest price. An intervention may be medically indicated and yet not be a covered benefit or meet this definition of medical necessity. Interventions that do not meet this definition of medical necessity may be covered at the choice of United. An intervention shall be considered cost effective if the benefits and harms relative to costs represent an economically efficient use of resources for patients with this condition. In the application of this criterion to an individual case, the characteristics of the individual patient shall be determinative.

(2) The following definitions shall apply to these terms only as they are used in this subsection;

(A) " Effective " means that the intervention can be reasonably expected to produce the intended results and to have expected benefits that outweigh potential harmful effects.

(B) " Health intervention " means an item or service delivered or undertaken primarily to treat a medical condition or to maintain or restore functional ability. For this definition of medical necessity, a health intervention shall be determined not only by the intervention itself, but also by the medical condition and patient indications for which it is being applied.

(C) " Health outcomes " means treatment results that affect health status as measured by the length or quality of a person's life.

(D) " Medical condition " means a disease, illness, injury, genetic or congenital defect, pregnancy, or a biological or psychological condition that lies outside the range of normal, age-appropriate human variation.

(E) " New intervention " means an intervention that is not yet in widespread use for the medical condition and patient indications under consideration.

(F) " Scientific evidence " means controlled clinical trials that either directly or indirectly demonstrate the effect of the intervention on health outcomes. However, if controlled clinical trials are not available, observational studies that demonstrate a causal relationship between the intervention and health outcomes may be used. Partially controlled observational studies and uncontrolled clinical series may be considered to be suggestive, but shall not by themselves be considered to demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be explained either by the natural history of the medical condition or potential experimental biases.

(G) " Treat " means to prevent, diagnose, detect, or palliate a medical condition.

(H) " Treating physician " means a physician who has personally evaluated the patient.

(3) Each new intervention for which clinical trials have not been conducted because of epidemiological reasons, including rare or new diseases or orphan populations, shall be evaluated on the basis of professional standards of care or expert opinion as described below in paragraph(4).

(4) The scientific evidence for each existing intervention shall be considered first and, to the greatest extent possible, shall be the basis for determinations of medical necessity. If no scientific evidence is available, professional standards of care shall be considered. If professional standards of care do not exist, or are outdated or contradictory, decisions about existing interventions shall be based on expert opinion. Coverage of existing interventions shall not be denied solely on the basis that there is an absence of conclusive scientific evidence. Existing interventions may be deemed to meet this definition of medical necessity in the absence of scientific evidence if there is a strong consensus of effectiveness and benefit expressed through up-to-date and consistent professional standards of care or, in the absence of those standards, convincing expert opinion.

3.2 **Medicaid Eligibility.** If applicable, Provider must meet minimum requirements for participation in the State Programs. Provider may meet this requirement either by being enrolled with the State as a Medicaid provider or by demonstrating to Subcontractor and Health Plan that it meets the applicable minimum requirements for Medicaid participation. Subcontractor and Health Plan will exclude from its network any provider who has been suspended from the Medicare or Medicaid program in any state.

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

3.4 **Hours of Operation; Appointments.** Provider shall offer hours of operation that are no less than the hours of operation offered to commercial beneficiaries or comparable to Medicaid fee-for-service if Provider serves only Medicaid beneficiaries.

3.5 **Hold Harmless.** Except for applicable cost-sharing requirements under the State Contract, Provider shall look solely to Subcontractor or Health Plan (as applicable) for payment of Covered Services provided to Covered Persons pursuant to the Agreement and the State Contract and hold the State, the U.S. Department of Health and Human Services and Covered Persons harmless in the event that Subcontractor or Health Plan cannot or will not pay for such Covered Services. In accordance with 42 CFR Section 447.15, as may be amended from time to time, the Covered Person is not liable to Provider for any services for which Subcontractor or Health Plan is liable and as specified under the State's relevant health insurance or managed care statutes, rules or administrative agency guidance. Provider shall not require any copayment or cost sharing for Covered Services provided under the Agreement unless expressly permitted under the State Contract. Provider shall also be prohibited from charging Covered Persons for missed appointments if such practice is prohibited under the State Contract or applicable law. This provision shall survive any termination of the Agreement, including breach of the Agreement due to insolvency.

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

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

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

3.9 **Subcontracts.** If Provider subcontracts or delegates any functions of the Agreement, in accordance with the terms of the Agreement, the subcontract or delegation must include all of the requirements of this Appendix, and applicable requirements of the State Contract. 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.

3.10 **Records Retention.** As required under State or federal law or the State Contract, Provider shall maintain an adequate record keeping system for recording services, charges, dates and all other commonly accepted information elements for services rendered to Covered Persons. Such records shall be maintained for a period specified by the State Contract, or such other period as required by law. If records are under review or audit, they must be retained until the review or audit is complete. Prior approval for the disposition of records must be requested and approved by Subcontractor and Health Plan if the Agreement is continuous.

3.11 **Records Access.** Provider acknowledges and agrees that the State, the U.S. Department of Health and Human Services and other authorized federal and state personnel shall have the right to evaluate through audit, inspection or other means, any records pertinent to the State Contract, including records pertaining to the quality, appropriateness and timeliness of services performed under the State Contract.

3.12 **Government Audit; Investigations.** Provider acknowledges and agrees that the State and the U.S. Department of Health and Human Services or their authorized representatives shall have the right to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services provided under the terms of the State Contract and any other applicable rules. There shall be no restrictions on the right of the State or federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness or timeliness of services provided pursuant to the State Contract and the reasonableness of their costs.

3.13 **Privacy; HIPAA.** Provider shall comply with all applicable privacy rule and security rule provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and associated implementing regulations, as may be amended from time to time, and shall safeguard information about Covered Persons in accordance with applicable federal and State privacy laws and rules including 42 CFR §438.224 and 42 CFR Part 431, Subpart F, as may be amended from time to time.

3.14 **Protected Health Information (PHI).** Provider and its employees, providers, agents and subcontractors shall maintain reasonable and appropriate administrative, technical, and physical safeguards to ensure the integrity and confidentiality of all protected health information ("PHI") it receives or possesses in the course of carrying out the responsibilities of the Agreement. Data containing Private Health Information or Personal Identification Information shall not be transmitted to or processed at any site outside of the United States. Provider acknowledges and agrees that PHI related to Covered Services performed under the Agreement remains the ownership of the Department and the Department shall have the right to review any agreements that use or disclose the PHI. Provider shall notify Subcontractor and Health Plan

immediately of any use or disclosure of PHI or other confidential information not allowed by the provisions of the Agreement of which it becomes aware and of any instance where the PHI is subpoenaed, copied or removed by anyone except an authorized representative of the Department, Subcontractor or Health Plan.

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

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

(b) 42 CFR 434 and 42 CFR 438.6, as may be amended from time to time.

(c) 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."

(d) 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.

(e) The Immigration and Reform Control Act of 1986 (IRCA), as may be amended from time to time. This Act, with certain limitations, requires the verification of the employment status of all individuals who were hired on or after November 6, 1986.

3.16 **Physician Incentive Plans.** In the event Provider participates in a physician incentive plan ("PIP") under the Agreement, Provider agrees that such PIPs must comply with 42 CFR 417.479, 42 CFR 438.6(h), 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 Covered Person. PIPs must not contain provisions that provide incentives, monetary or otherwise, for the withholding of Medically Necessary care.

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

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

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

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

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

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

Provider is obligated to screen its employees and contractors to determine whether any of them have been excluded from participation in Medicare, Medicaid, CHIP, or any Federal Health Care Programs (as defined in Section 1128B(f) of the Social Security Act). Provider shall not employ or contract with an individual or entity that has been excluded. Provider shall immediately report to Subcontractor any exclusion information discovered. Provider acknowledges and agrees that 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. 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.

Subcontractor must exclude from its network any provider who has been excluded from the Medicare or Medicaid program in any state.

3.19 **Disclosure.** Provider shall cooperate with Subcontractor in disclosing information the Department may require related to ownership and control, significant business transactions, and persons convicted of crimes in accordance with 42 C.F.R. §§ 455.104, 455.105, and 455.106.

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

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

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

In accordance with Health Plan's policies and the Deficit Reduction Act of 2005 (DRA), if Provider receives annual Medicaid payments of at least five million dollars ($5,000,000) (cumulative, from all sources), 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); (b) cite administrative remedies for false claims and statements (established under chapter 38 of title 31, United States Code) and whistleblower protections under federal and state laws; (c) reference state laws pertaining to civil or criminal penalties for false claims and statements; and (d) with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in federal health care programs (as defined in section 1128B(f)), include as part of such written policies, detailed provisions regarding Provider's policies and procedures for detecting and preventing fraud, waste, and abuse. Provider agrees to train its staff on the aforesaid policies and procedures.

3.23 **Data; Reports.** Provider shall timely submit all reports and clinical information required by Subcontractor and Health Plan, including child health check-up reporting, if applicable. Provider shall also submit timely, complete and accurate encounter data to Subcontractor and Health Plan (as applicable) in accordance with the requirements of Health Plan and the State Contract.

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

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

3.26 **Staff Qualifications.** Provider shall ensure that all staff performing Covered Services under the Agreement are appropriately licensed and qualified to perform such services.

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

3.28 **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 Part 438, including but not limited to 438.6(f)(2)(i).

3.29 **Transition of Covered Persons.** Provider shall cooperate with Subcontractor and Health Plan in the event an immediate transfer to another primary care physician or Medicaid managed

care contractor is warranted if the Covered Person's health or safety is in jeopardy, as may be required under law.

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

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

SECTION 4
HEALTH PLAN AND SUBCONTRACTOR REQUIREMENTS

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

4.2 **Time to file claims**. Claims shall be received by Subcontractor or Health Plan (as applicable) within the timeframe set forth in the Agreement but in no event shall Subcontractor or Health Plan impose a timeframe such that Subcontractor or Health Plan must receive claims from Provider less than 90 days from the date of service, or, in the event Health Plan is a secondary payer, in no event shall Subcontractor or Health Plan impose a timeframe such that Subcontractor or Health Plan must receive claims from Provider less than 90 days from the date Provider receives notice of adjudication from the primary payer. Provider may request an additional 30 days to submit a claim if good cause is shown and Subcontractor or Health Plan shall not unreasonably deny Provider's request for an extension. Claims shall be submitted for Medicaid beneficiaries with retroactive eligibility in accordance with United's policy on retroactive eligibility as specified in the Provider Administrative Guide.

4.3 **Prior Authorizations**. All prior authorization reviews and communications will be conducted in compliance with all applicable state and federal laws, the State Contract and applicable attachments. Subcontractor or Health Plan (as applicable) will establish a process that will allow Provider to submit and receive determination via a secure electronic transmission.

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

4.5 **Provider Discrimination Prohibition.** In accordance with 42 CFR 438.12 and 438.214(c), neither Health Plan nor Subcontractor shall discriminate with respect to the participation, reimbursement or indemnification of a provider who is acting within the scope of such provider's license or certification under applicable State law, solely on the basis of such license or certification. Further, Health Plan and Subcontractor shall not discriminate with respect to the participation, reimbursement or indemnification of any provider who serves high-risk Covered Persons or specializes in conditions requiring costly treatments. This provision shall not be construed as prohibiting Health Plan or Subcontractor from limiting a provider's participation to the extent necessary to meet the needs of Covered Persons. This provision also is not intended and shall not interfere with measures established by Health Plan and Subcontractor that are designed to maintain quality of care practice standards and control costs.

4.6 **Communications with Covered Persons.** Neither Health Plan nor Subcontractor shall prohibit or otherwise restrict Provider, when acting within the lawful scope of practice, from advising or advocating on behalf of a Covered Person for the following:

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

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

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

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

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

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

SECTION 5
OTHER REQUIREMENTS

5.1 **Compliance with State Contract.** All tasks performed under the Agreement shall be performed in accordance with the requirements of the State Contract, as set forth in this Appendix, applicable provider manuals, and protocols, policies and procedures that

Subcontractor has provided or delivered to Provider. The applicable provisions of the State Contract are incorporated into the Agreement by reference. Nothing in the Agreement relieves Health Plan of its responsibility under the State Contract. If any provision of the Agreement is in conflict with provisions of the State Contract, the terms of the State Contract shall control and the terms of the Agreement in conflict with those of the State Contract will be considered waived.

5.2 **Monitoring.** Subcontractor 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 shall identify to Provider any deficiencies or areas for improvement mandated under the State Contract and Provider and Subcontractor shall take appropriate corrective action. Provider shall comply with any corrective action plan initiated by Subcontractor, Health Plan and/or required by the State Program. In addition, Provider shall monitor and report the quality of services delivered under the Agreement and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which Subcontractor and Provider practice and/or the performance standards established under the State Contract.

Claim Reconsideration, Appeal and State Fair Hearing Process

Claim Reconsideration:

- Reconsideration is defined as a request by a provider for an MCO to review a claim decision.
- Reconsideration is an optional process available to providers prior to submitting an appeal.
- Requests must be submitted within 120 calendar days from the remittance date, plus 3 calendar days if the notice is mailed.
- Reconsideration requests can be submitted through various means:
  - Phone: 877-542-9235
  - Electronically: www.unitedhealthcareonline.com
  - Paper: UnitedHealthcare Community Plan
PO Box 31350
Salt Lake City, UT 84131-0350
- Providers may terminate the reconsideration process and submit a formal appeal request within 60 calendar days of the original remittance notice of action, plus 3 calendar days if the notice is mailed.
- If you disagree with a claim reconsideration decision, you have the right to file a formal claim appeal within 60 calendar days of the reconsideration notice of action.
- Providers have the right to represent him/herself or be represented by legal counsel or another spokesperson when requesting reconsideration or an appeal.

Appeal:

- Appeal must be filed in writing within 60 calendar days of the date of the provider remittance or notice of action, plus 3 calendar days if the notice is mailed.
- Request must state in the document this is a "formal appeal".
- State the specific reason for denial as stated on the remittance or notice of action.
- Enclose all relevant documentation with the appeal request.
- Filing an appeal is final. Providers cannot submit a reconsideration following the appeal decision.
- Send written request via regular mail to:
UnitedHealthcare
Attention: Formal Grievances and Claim Appeals
PO Box 31364
Salt Lake City, UT 84131-0364
- If you disagree with the appeal outcome, you can file a State Fair Hearing.

State Fair Hearing:

- Providers must exhaust UHC appeal process prior to submitting a State Fair Hearing.
- Request must specifically request a "fair hearing" and should describe the decision appealed and the specific reasons for the appeal.
- Requests must be submitted within 30 calendar days from the date of the notice of the action, plus 3 calendar days if the notice is mailed.
- Send written request via regular mail to:
Office of Administrative Hearings
1020 S. Kansas Avenue
Topeka, KS 66612

Refer to Chapter 15 of the Provider Administrative Guides found on UHC Community Plan for additional information.