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.