VIRGINIA STATE PROGRAM(S)

REGULATORY REQUIREMENTS APPENDIX

DOWNSTREAM PROVIDER

THIS VIRGINIA STATE PROGRAM(S) REGULATORY REQUIREMENTS APPENDIX (this "Appendix") supplements and is made part of the provider agreement (the "Agreement") between UnitedHealthcare Insurance Company or one of its Affiliates and the party named in the Agreement ("Provider").

SECTION 1
APPLICABILITY

The requirements of this Appendix apply to Medicaid benefit plans sponsored, issued or administered by UnitedHealthcare Insurance Company, or one of its affiliates (referred to in this Appendix as "United") under the Commonwealth of Virginia's Medicaid and CHIP Programs, including the Cardinal Care 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 United is required to amend or supplement this Appendix as required or requested by the State to comply with federal or State regulations, United 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 **Affiliate:** Those entities controlling, controlled by, or under common control with UnitedHealthcare Insurance Company.

2.2 **Covered Person:** An individual who is currently enrolled with United 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 United to receive coverage under the State Contract.

2.4 **Department:** The Department of Medical Assistance Services (DMAS).

2.5 **State:** The Commonwealth of Virginia or its designated regulatory agencies.

2.6 **State Contract:** Collectively, the Cardinal Care Program contract between United and the Department of Medical Assistance Services (DMAS) for the purpose of providing and paying for Covered Services to Covered Persons enrolled in the State Program.

2.7 **State Program:** The Commonwealth of Virginia's Medicaid and CHIP Programs, including the Cardinal Care Program. 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 United and Provider agree to undertake, which include the following:

3.1 **Definitions Related to the Provision of Covered Services.** Provider shall follow the applicable State Contract'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:

i) Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance use disorder) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body functions, or serious dysfunction of any bodily organ or part; or with respect to a pregnant woman who is having contractions, (1) that there is inadequate time to effect a safe transfer to another hospital before delivery, or (2) that transfer may pose a threat to the health or safety of the woman or the unborn child.

ii) Emergency Services: Those health and/or behavioral health care services that are rendered by participating or non-participating providers, after the sudden onset of a medical condition manifesting itself by acute symptoms or behavior 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: (1) placing the client's health or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy; (2) serious impairment to bodily or mental functions; or (3) serious dysfunction of any bodily organ or part or behavior.

iii) Medically Necessary or Medical Necessity for the Medallion 4.0 Program: Appropriate and necessary health care services which are rendered for any condition which, according to generally accepted principles of good medical practice, requires the diagnosis or direct care and treatment of an illness, injury, or pregnancy-related condition, and are not provided only as a convenience. Services must be sufficient in amount, duration, and scope to reasonably achieve their purpose. For children under age 21, medical necessity review must fully consider Federal EPSDT guidelines.

iv) Medically Necessary or Medical Necessity for the Cardinal Care Program waiver: Per Virginia Medicaid, an item or service provided for the diagnosis or treatment of an enrollee's condition consistent with standards of medical practice and in accordance with Virginia Medicaid policy (12 VAC 30-130-600) and EPSDT criteria (for those under age 21), and federal regulations as defined in 42 C.F.R. § 438.210 and 42 C.F.R. § 440.230.

3.2 Medicaid or CHIP Participation. Provider must be enrolled with the State as a Medicaid or CHIP provider, as applicable, to participate in United's Medicaid or CHIP network. Upon notification from the State that Provider's enrollment has been denied or terminated, United must terminate Provider immediately and will notify affected Covered Persons that Provider is no longer participating in the network. United will exclude from its network any provider who has been terminated or suspended from Medicare, Medicaid or CHIP 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. Additionally, Provider agrees not to create barriers to access care by imposing requirements on Covered Persons that are inconsistent with the provision of medically necessary and covered Medicaid services. Provider agrees to abide by the terms of the Medicaid contract for the timely provision of emergency and urgent care. Where applicable, the Provider agrees to follow those procedures for handling urgent and emergency care cases stipulated in any required hospital/emergency department Memorandums of Understanding signed by United in accordance with the State Contract.

The Provider agrees to act as a PCP for a predetermined number of members, not to exceed the panel size limits set forth in Section 4.7.F of the Medallion State Contract.

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. As applicable, Provider will make Covered Services available 24 hours a day, 7 days a week when medically necessary.

3.5 Balance Billing. In accordance with 42 CFR § 447.15, Provider shall accept United's payment as payment in full except for any applicable cost-sharing requirements under the State Contract, and shall not bill or balance bill Covered Persons for Covered Services provided during the Covered Person's enrollment period. The collection or receipt of any money, gift, donation or other consideration from or on behalf of a Covered Person for any Covered Service provided is expressly prohibited. Provider agrees to hold Covered Persons harmless for charges for any Medicaid covered service. This includes those circumstances where the Provider fails to obtain necessary referrals, service authorization, or fails to perform other required administrative functions. Should an audit by United or an authorized State or federal official result in disallowance of amounts previously paid to Provider, Provider will reimburse United upon demand. Provider shall not bill Covered Persons in these instances. Provider agrees not to bill Covered Person for Medically Necessary services covered under the State Contract and provided during the Covered Person's period of enrollment with United. This provision shall continue to be in effect even if United becomes insolvent.

If the service is a non-Medicaid covered service, prior to providing the service, Provider shall inform the Covered Person of the non-Medicaid covered service and have the Covered Person acknowledge the information. If the Covered Person agrees in advance of receiving the service and in writing to pay for a non-Medicaid covered service, then the Provider can bill the Covered Person. If United determines a Covered Person was charged for Covered Services inappropriately, such payment may be recovered, as applicable.

Provider is subject to criminal penalties if Provider knowingly and willfully charges for any service provided to a Covered Person under the State Plan or covered under the Cardinal Care Program Contract, money or other consideration at a rate in excess of the rate established by the Department, as specified in section 1128B (d)(1) of the Social Security Act (42 U.S.C. § 1320a-

7(b), as amended. This provision shall continue to be in effect even if United becomes insolvent until such time as Covered Persons are withdrawn from assignment to United.

Pursuant to section 1932(b)(6), (42 U.S.C. § 1396u-2 (b)(6)), Provider shall not hold a member liable for:

i) Debts of United in the event of United's insolvency.

ii) Payment for services provided by United if United has not received payment from the Department for the services or if Provider, under contract or other arrangement with United, fails to receive payment from the Department or United.

iii) Payments to Provider that are in excess of the amount that normally would be paid by the Covered Person if the service had been received directly from United.

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 its employees harmless from and against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses, including court costs and attorney fees, to the extent proximately caused by any negligent act or other intentional misconduct or omission of Provider, its agents, officers, employees or contractors arising from the Agreement. The Department may waive this requirement for public entities if Provider is a state agency or sub-unit as defined by the State or a public health entity with statutory immunity. No terms of this Agreement are valid which terminate the legal liability of United in the State Contract. This clause shall survive the termination of the Agreement for any reason, including breach due to insolvency

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 United delegates credentialing to Provider, United will provide monitoring and oversight and Provider shall ensure that all licensed medical professionals are credentialed in accordance with United'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, applicable requirements of the State Contract, and applicable laws and regulations. Provider further agrees to promptly amend its agreements with such subcontractors, in the manner requested by United, 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. All financial records shall follow generally accepted accounting principles. Medical records and supporting management systems shall include all pertinent information related to the medical management of each Covered Person. Other records shall be maintained as necessary to clearly reflect all actions taken by Provider related to services provided under the State Contract. All records and reports relating to this State Contract shall be retained by United for a period of ten (10) years after final payments is made under this State Contract or in the event that this State Contract is renewed, ten (10) years after the renewal date. For Covered Persons under age 21 enrolled in the Cardinal Care Program, Provider shall retain records for the greater period of a minimum of 10 years or at least 6 years after the minor has reached 21 years of age per 12VAC 30-120-1730. As applicable, Provider shall maintain the special reporting requirements on sterilizations and hysterectomies stipulated in the State Contract.

3.11 Records Access. Provider acknowledges and agrees that the State, the U.S. Department of Health and Human Services, the State Medicaid Fraud Unit, and other authorized federal and State personnel shall have complete access to all records pertaining to services provided to Covered Persons. Provider shall provide immediate access to facilities, records and supportive materials pertinent to the State Contract for State or federal fraud investigators. Provider agrees otherwise to preserve the full confidentiality of medical records in accordance with the State Contract.

Provider shall provide a copy of a Covered Person's medical records to the Covered Person, United and/or their authorized representatives as required by United and within no more than 10 business days of a request.

3.12 Government Audit; Investigations. The State, the Department, the Centers for Medicare & Medicaid Services (CMS), the U.S. Department of Health and Human Services (HHS) inspector general, the comptroller general, or their designees have the right to audit, evaluate, copy and inspect any books, records, contracts, computers, or other electronic systems of Provider, that pertain to the ability of Provider and/or its subcontractors to bear the risk of financial losses, or any aspect of services and activities performed, or determination of amounts payable under United's contract with the State.

i) Provider will make available, for purposes of an audit, its premises, physical facilities, equipment, books, records, contracts, computers, or other electronic systems related to Covered Persons.

ii) The right to audit will exist through 10 years from the final date of the State Contract period or from the date of completion of any audit, whichever is later.

iii) If the State, CMS, or HHS inspector general determines that there is a reasonable probability of fraud or similar risk, the State, CMS, or HHS inspector general may inspect, evaluate, and audit the Provider at any time.

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; Confidentiality. Provider understands that the use and disclosure of information concerning Covered Persons is restricted to purposes directly connected with the administration of the State Program and shall maintain the confidentiality of Covered Person's information and records as required by the State Contract and in federal and State law including, but not limited to, all applicable privacy, security and Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Public Law 104-191, and associated implementing regulations, including but not limited to 45 CFR Parts 160, 162, 164, as applicable and as may be amended from time to time, and shall safeguard information about Covered Persons in accordance with applicable federal and State privacy laws and rules including but not limited to 42 CFR §438.224, 42 CFR Part 2, and 42 CFR Part 431, Subpart F; 42 CFR Part 434 and 42 CFR 438.6 (if applicable), as may be amended from time to time.

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

Federal and State Medicaid regulations, and some other federal and State laws and regulations, including but not limited to those listed above, are often more stringent than the HIPAA regulations. Provider shall notify United and the Department of any breach of confidential information related to Covered Persons within the time period required by applicable federal and State laws and regulations following actual knowledge of a breach, including any use or disclosure of confidential information, any breach of unsecured PHI, and any Security Incident (as defined in HIPAA regulations) and provide United and the Department with an investigation report within the time period required by applicable federal and State laws and regulations following the discovery. Provider shall work with United and the Department to ensure that the breach has been mitigated and reporting requirements, if any, complied with.

Provider shall comply with the breach notification rules under the Health Information Technology for Economic and Clinical Health (HITECH) Act and the Genetic Information Nondiscrimination Act including but not limited to 42 CFR §438.230 (c)(2); 45 CFR parts 160 and 164, subparts A and E; and State Contract Sections 5.2.B and 10.5.

Provider agrees to ensure confidentiality of family planning services in accordance with the State Contract, except to the extent required by law, including, but not limited to, the Virginia Freedom of Information Act.

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

i) Title VI of the Civil Rights Act of 1964; title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the

Rehabilitation Act of 1973; Americans with Disabilities Act; and section 1557 of the Patient Protection and Affordable Care Act, and their implementing regulations, as may be amended from time to time.

ii) All relevant federal and State statutes, regulations and orders related to equal opportunity in employment, including but not limited to compliance with E.O. 11246, "Equal Employment Opportunity," as amended by E.O. 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and as supplemented by regulations at 41 CFR part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor."

iii) If the Agreement is for an amount in excess of $100,000, Provider shall comply with all applicable standards, orders or regulations issued pursuant to the Clean Air Act, 42 U.S.C. 7401 et seq., and the Federal Water Pollution Control Act, as amended, 33 U.S.C. 1251 et seq. Any violations shall be reported to DHHS and the appropriate Regional Office of the Environmental Protection Agency.

iv) The Affordable Care Act Contractor policies and procedures, including but not limited to, reporting overpayments pursuant to state or federal law.

3.15 Physician Incentive Plans. In the event Provider participates in a physician incentive plan ("PIP") under the Agreement, Provider agrees that such PIPs must comply with 42 CFR 417.479, 42 CFR 438.3, 42 CFR 422.208, and 42 CFR 422.210, as may be amended from time to time. Neither United 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 services that meet the definition of Medical Necessity.

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

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

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

complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

3.17 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 employees, principals, nor any providers, subcontractors or consultants or persons with an ownership (owning 5 percent or more of the Provider's equity) or controlling interest in the Provider (an owner including the Provider himself or herself), or an agent or managing employee of the Provider, with whom Provider contracts and who are providing items or services that are significant and material to Provider's obligations under the Agreement is:

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

ii) debarred, suspended 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 shall screen their employees and contractors initially and on an ongoing monthly basis to determine whether any of them has 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) and not employ or contract with an individual or entity that has been excluded or debarred. Provider will conduct monthly checks to screen their employees and contractors for exclusion, using the Social Security Administration's Death Master File, the National Plan and Provider Enumeration System (NPPES), the List of Excluded Individuals/Entities (LEIE), the System for Award Management (SAM), and any other databases as the State may prescribe. Provider shall immediately report to United any exclusion information discovered. Provider acknowledges and agrees that payment will not be made for any items or Covered Services provided by an excluded individual pursuant to 42 CFR §1001.1901(b) and is obligated to screen all employees, contractors, and subcontractors for exclusion as required under applicable State and federal laws. Additionally, Provider acknowledges that pursuant to 42 CFR §1003.102(a)(2) civil monetary penalties may be imposed against Provider if he or she employs or enters into contracts with excluded individuals or entities to provide items or Covered Services to Covered Persons under this Agreement. Provider agrees not to employ or subcontract with individuals or entities whose owner, those with a controlling interest, or managing employees are on a State or federal exclusion list to provide items or Covered Services under this Agreement. Provider can search the HHS-OIG website, at no cost, by the names of any individuals or entities. The database is called LEIE and can be accessed at http://www.oig.hhs.gov/fraud/exclusions.asp. The GSA EPLS/SAM database can be accessed at https://www.sam.gov. Federal and State exclusion databases must be reviewed monthly to ensure that no employee or contractor has been excluded. Applicable state exclusion databases can be accessed through the State's Medicaid website. United will terminate the Agreement immediately and exclude from its network any provider who has been terminated from the Medicare, Medicaid or CHIP program in any state. United may also terminate the Agreement if Provider or Provider's owners, agents, or managing employees are found to be excluded on a State or federal exclusion list.

3.18 Disclosure. Provider must be screened and enrolled into the State's Medicaid or CHIP program, as applicable, and disclose the required information, at the time of application, credentialing, and/or re-credentialing, and/or upon request, in accordance with 42 CFR§ 455

Subpart B, as related to ownership and control, business transactions, and criminal conviction for offenses against Medicare, Medicaid, CHIP and/or other Federal health care programs. See 42 CFR § 455, Parts 101 through 106 for definitions, percentage calculations, and requirements for disclosure of ownership, business transactions, and information on persons convicted of crimes related to any Federal health care programs. Provider must submit information related to ownership and control of subcontractors or wholly owned suppliers within thirty-five (35) calendar days of a request for such information in accordance with 42 CFR 455.105. Additionally, Provider must cooperate with the Department for submission of fingerprints upon a request from the Department or CMS in accordance with 42 CFR 455.434.

3.19 Cultural Competency and Access. Provider shall participate in United'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, physical or mental disabilities, diverse cultural and ethnic backgrounds, and regardless of gender, sexual orientation or gender identity, and shall provide interpreter services in a Covered Person's primary language and for the hearing impaired for all appointments and emergency services. Provider shall provide information to Covered Persons regarding treatment options and alternatives, as well as information on complaints and appeals, in a manner appropriate to the Covered Person's condition and ability to understand.

Provider shall make written membership material available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited (42 C.F.R. § 438.10(d)(1)(ii)). All marketing materials for Cardinal Care State Contract Covered Persons or potential Covered Persons shall use easily understood language formats and shall meet the information requirements outlined in 42 CFR 438.10. All marketing and informational materials related to the Medallion State Contract shall achieve a Flesch total readability score of forty (40) or better (at or below a 12th grade educational level). The document must set forth the Flesch score and certify compliance with this standard. Oral interpretation services must be available to ensure effective communication regarding treatment, medical history, or health education (42 C.F.R. § 438.10(c)(4)). Trained professionals shall be used when needed where technical, medical, or treatment information is to be discussed with the Covered Person, a family member, or a friend.

Provider shall provide physical access, reasonable accommodations, and accessible equipment for Covered Persons with physical or mental disabilities.

3.20 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 United to submit to the State Program for prior approval.

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

In accordance with United's policies and the Deficit Reduction Act of 2005 (DRA), Provider shall have written policies for its employees, contractors or agents that: (a) provide detailed information about the federal False Claims Act (established under sections 3729 through 3733 of

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

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

When applicable, Provider is required to report, respond to, and document critical incidents to the United in accordance with applicable requirements.

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

3.24 Claims Information. Consistent with 42 CFR 447.45, Provider shall submit all claims to United no later than 12 months from the date of service for which Provider requests reimbursement. Provider shall submit to United the information needed to make payment and shall identify third party liability coverage, including Medicare and other insurance, and if applicable seek such third party liability payment before submitting claims to United. Provider understands and agrees that each claim Provider submits to United constitutes a certification that the claim is true and accurate to the best of Provider's knowledge and belief and that the Covered Services are 1) Medically Necessary and 2) have been provided to the Covered Person prior to submitting the claim.

3.25 Compliance with Medicaid Laws and Regulations. Provider agrees to abide by the Medicaid laws, regulations, including applicable sub regulatory guidance, and program instructions to the extent applicable to Provider in Provider's performance of the Agreement. Provider understands that payment of a claim by United or the State is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited to, federal requirements on fraud, waste and abuse, disclosure, debarment, termination and exclusion screening), and is conditioned on the Provider's compliance with all applicable conditions of participation in Medicaid. Provider understands and agrees that each claim Provider submits to United constitutes a certification that Provider has complied with all applicable Medicaid laws, regulations and program instructions in connection with such claims and the services provided therein. Provider's payment of a claim will be denied if Provider is terminated or excluded from participation in federal healthcare programs. Provider's payment of a claim may be temporarily suspended if the State or United provides notice that a credible allegation of fraud exists and there is a pending investigation. Provider's payment of a claim may also be temporarily suspended or adjusted if the Provider bills a claim with a code that does not match the service provided. United performs coding edit procedures based primarily on National Correct Coding Initiative (NCCI) policies and other nationally recognized and validated policies. Provider agrees that it will provide medical records to United upon its request in order to determine appropriateness of coding. Provider may dispute any temporarily suspended or adjusted payment consistent with the terms of the Agreement.

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

3.27 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 United 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. Claims for services performed during any period of noncompliance with these license requirements will be denied.

3.28 Clinical Laboratory Improvements Act (CLIA) certification or waiver. As applicable, if Provider performs any laboratory tests on human specimens for the purpose of diagnosis and/or treatment, Provider agrees to acquire and maintain the appropriate CLIA certification or waiver for the type of laboratory testing performed. Provider further agrees to provide a copy of the certification if requested by United. A State authorized license or permit that meets the CLIA requirements may be substituted for the CLIA certificate pursuant to State law. Those laboratories with certificates of waiver will provide only the types of tests permitted under the terms of the waiver. Medicare and Medicaid programs require the applicable CLIA certification or waiver for the type of services performed as a condition of payment. Provider must include the appropriate CLIA certificate or waiver number on claims submitted for payment for laboratory services.

3.29 Quality; Utilization Management. Pursuant to any applicable provider manuals and related protocols, or as elsewhere specified under the Agreement, Provider agrees to cooperate with United's quality improvement and utilization review and management activities. This shall include, but not be limited to, participation in any internal and external quality assurance, utilization review, peer review, and grievance procedures established by United 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 United or Provider. Provider shall adhere to the quality assurance and utilization review standards of the State Program and shall monitor quality and initiate corrective action to improve quality consistent with the generally accepted level of care. Provider also agrees to contribute required data to United's quality improvement and other assurance programs as required in the State Contract.

3.30 Immediate Transfer. Provider shall cooperate with United 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.

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

3.32 Continuity of Care. Provider shall cooperate with United and provide Covered Persons with continuity of treatment, including coordination of care to the extent required under law and according to the terms of the Agreement and the State Contract. In the event Provider's participation with United terminates during the course of a Covered Person's treatment by Provider, except in the case of death or illness, Provider shall notify United at least thirty (30) days in advance of disenrollment and shall continue care for the Covered Persons within his or her panel for up to thirty (30) day after such notification, until another PCP is chosen or assigned.

Provider shall assure that Covered Persons can continue treatment of any medications prescribed or authorized by DMAS or another Provider as required by the State Contract and applicable law. Service authorizations ("SA") issued by the Department or United shall be honored as provided through DMAS transition reports and by United for the duration of the SA or for 30 calendar days from enrollment, whichever comes first. This does not preclude United from working with the Covered Person and Provider to resolve polypharmacy concerns.

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

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

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

3.36 Complaints; Appeals. Provider appeals are governed by the Virginia Administrative Process Act (Virginia Code § 2.2-4000 et seq.) and the Department's provider appeals regulations 12 VAC 30-20-500 through 12 VAC 30-20-560. Provider has the right to appeal adverse decisions to the

Department. However, United's internal appeal process must be exhausted prior to a Provider filing an appeal with the DMAS Appeals Division. United shall assist DMAS by presenting the Department's position in the administrative appeals process in conjunction with appeals of Contractor actions filed by providers.

3.37 Health Care Acquired/Preventable Conditions. No reduction in payment for a provider preventable condition ("PPC") shall be imposed on Provider when the condition defined as a PPC for a particular Covered Person existed prior to the initiation of treatment for that Covered Person by Provider.

Under 42 CFR §§ 438.3(g), 434.6(a)12(i), and 447.26(b), United is prohibited from making a payment to Provider for provider-preventable conditions that meet the following criteria:

i) Is identified in the State Plan;

ii) Has been found by the Department, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines;

iii) Has a negative consequence for the beneficiary;

iv) Is auditable;

v) Includes, at a minimum, wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

Provider must report to United provider preventable conditions associated with claims for payment or member treatments for which payment would otherwise be made. Non-payment of provider-preventable conditions shall not prevent access to services for Covered Persons.

3.38 Coordination of Other Coverage; Other Payment Sources. United is responsible for coordination of benefits for Covered Persons. Provider shall notify United on a monthly basis of any Covered Persons it has identified during that past month who were discovered to have comprehensive health coverage, including but not limited to workers' compensation insurance, or other non-health insurance coverage. Provider shall also notify United on a monthly basis of any Covered Person identified during the past month that has died and is over the age of 55.

3.39 Behavioral Health Providers. If Provider is a behavioral health service provider, Provider must meet DMAS' qualifications as outlined in the most current DMAS behavioral health provider manuals, including the community mental health rehabilitative services, mental health clinic, ARTS manual and psychiatric services provider manuals found at: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual

3.40 EDCD and Tech Waivers Providers. If Provider is providing services to Covered Persons who participate in the Cardinal Care Program waiver, in addition to all applicable laws and regulations, Provider must comply with the provider requirements as established in the DMAS provider manuals available at: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal.

3.41 **Covered Persons' Rights.** Provider shall comply with applicable federal and State laws that pertain to Covered Persons' rights. At a minimum, these rights shall include the right to, 1) receive information in accordance with 42 CFR 438.10, 2) be treated with respect and with due consideration or his or her dignity and privacy, 3) receive information on available treatment options and alternatives presented in a manner appropriate to the Covered Person's condition and ability to understand, 4) participate in decisions regarding his or her health care, including the right to refuse treatment, 5) be free from restraint/seclusion, 6) request/receive a copy of his or her medical records and request that they be amended or corrected, as specified in 45 CRF 164.524 and 45 CRF 164.526, 7) have free exercise of rights and the exercise of those rights does not adversely affect the way the Covered Person is treated and 8) be furnished health care services in accordance with 42 CFR 438.206 through 438.210 as described in the State Contract.

3.42 **Anti-Discrimination**. Provider will conform to the provisions of the Federal Civil Rights Act of 1964, as amended, as well as the Virginia Fair Employment Contracting Act of 1975, as amended, where applicable, the Virginians With Disabilities Act, the Americans With Disabilities Act and §2.2-4311 of the *Virginia Public Procurement Act* (VPPA), State Contract, and any other applicable laws. If Provider is a faith-based organization, Provider shall not discriminate against any individual of goods, services, or disbursements made pursuant to the Agreement on the basis of the individual's religion, religious belief, refusal to participate in a religious practice, or on the basis of race, age, color, gender, national origin, sex, sexual orientation, gender identity, or disability and shall be subject to the same rules as other organizations that contract with public bodies to account for the use of the funds provided; however, if the faith-based organization segregates public funds into separate accounts, only the accounts and programs funded with public funds shall be subject to audit by the public body.

3.43 **Home and Community-Based Services**. As applicable, Providers shall comply with the CMS HCBS Settings Rule detailed in 42 C.F.R. § 441.301(c)(4)-(5).

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

3.45 **Health Records.** Provider agrees to cooperate with United to maintain and share a health record of all services provided to a Covered Person, as appropriate and in accordance with applicable laws, regulations and professional standards.

3.46 **Overpayment.** In accordance with 42 CFR 438.608(d)(2), Provider shall to report to United when it has received an overpayment and will return the overpayment to United within 60 calendar days after the date on which the overpayment was identified. Provider will notify United in writing of the reason for the overpayment.

3.47 **Medicaid Enterprise System (MES) Provider Services Solution (PRSS).** The Federal 21st Century Cures Act requires all providers, including servicing, ordering or referring providers, who serve Medicaid Customers through MCO networks to enroll directly with DMAS through the Medicaid PRSS Enrollment Portal. Provider must be screened, enrolled and periodically revalidated in the department's Medicaid Enterprise System Provider Services Solution. United shall have in place procedures to terminate the Provider's agreement immediately upon notification from the State that the Provider cannot be enrolled or revalidated.

SECTION 4
UNITED REQUIREMENTS

4.1 Prompt Payment. United shall pay Provider pursuant to the State Contract and applicable State and federal law and regulations, including but not limited to 42 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 United otherwise requests assistance from Provider, United will be responsible for third party collections in accordance with the terms of the State Contract. United may retract a payment made during a period when the enrollee was not eligible; Provider may subsequently invoice DMAS for payment.

Unless otherwise required or allowed by the State Contract, United shall:

i) pay providers that are nursing facilities, as that term is defined in the State Contract, community long term services and supports (LTSS providers), LTSS services when covered under ESPDT, community behavioral health, and ARTS providers within 14 days of receipt of the clean claim;

ii) pay providers that are nursing facilities no less than the Medicaid rate for Medicaid covered days, using DMAS' methodology, or a different negotiated rate as set forth in the Agreement;

iii) pay providers that are community LTSS providers, (including when these services are provided through EPSDT), community behavioral health, ARTS, and early intervention providers are paid no less than the current Medicaid FFS rate or a different negotiated rate as set forth in this Agreement.

iv) pay all other providers within 30 days of the receipt of a clean claim for Covered Services rendered to a Covered Person or within an agreed upon number of days as may be set forth in the Agreement.

4.2 No Incentives to Limit Medically Necessary Services. United 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.

4.3 Provider Discrimination Prohibition. United shall not discriminate with respect to participation, reimbursement, or indemnification of a provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification. United shall not discriminate against Provider for serving high-risk Covered Persons or if Provider specializes in conditions requiring costly treatments. This provision shall not be construed as prohibiting United from limiting 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 United that are designed to maintain quality of care practice standards and control costs.

4.4 Communications with Covered Persons. United shall not prohibit or otherwise restrict Provider, when acting within the lawful scope of practice, from advising or advocating on behalf of a Covered Person, regardless of whether benefits for such are provided under the State Contract, for the following:

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

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

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

iv) 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.

United 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.

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

4.6 Authorization Procedures. United shall follow service authorization procedures pursuant to the *Code of Virginia* § 38.2-3407.15:2 and comply with the requirements for prior authorization for covered outpatient drugs in accordance with section 1927 of the Social Security Act.

United must accept telephonic, facsimile, or electronic submissions of prior authorization requests that are delivered from e-prescribing systems, electronic health records, and health information exchange platforms that utilize the National Council for Prescription Drug Programs' SCRIPT standards for prior authorization requests.

SECTION 5
OTHER REQUIREMENTS

5.1 Compliance with State Contract. All tasks performed under the Agreement shall be performed in accordance with the requirements of the applicable State Contract, as set forth in this Appendix, applicable provider manuals, and protocols, policies and procedures that United 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 United of its responsibility under the State Contract. If any provision of the Agreement is in conflict with provisions of the State Contract, the terms of the State Contract shall control and the terms of the Agreement in conflict with those of the State Contract will be considered waived. Notwithstanding any other provision to the contrary, the obligations of the State shall be limited to annual appropriations by its governing body for the purposes of the Agreement.

5.2 Monitoring. United shall perform ongoing monitoring (announced or unannounced) of services rendered by Provider under the Agreement and shall perform annual and/or 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, United shall identify to Provider any

deficiencies or areas for improvement mandated under the State Contract and Provider and United shall take appropriate corrective action. Provider shall comply with any corrective action plan initiated by United 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 United and Provider practice and/or the performance standards established under the State Contract.

5.3 Enrollment. The parties acknowledge and agree that the State Program is responsible for enrollment, reenrollment and disenrollment of Covered Persons.

5.4 No Exclusivity. Nothing in the Agreement or this Appendix shall be construed as prohibiting or penalizing Provider for contracting with a managed care organization other than United or as prohibiting or penalizing United for contracting with other providers.

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

5.6 E-Verify Requirements. If applicable, Provider will comply with the E-Verify requirements in this section. In accordance with *Code of Virginia*, §2.2-4308.2, any employer with more than an average of 50 employees for the previous 12 months entering into a contract in excess of $50,000 with any agency of the State to perform work or provide services pursuant to such contract shall register and participate in the E-Verify program to verify information and work authorization of its newly hired employees performing work pursuant to such public contract. Any such employer who fails to comply with these provisions shall be debarred from contracting with any agency of the State for a period up to one year. Such debarment shall cease upon the employer's registration and participation in the E-Verify program. If requested, the employer shall present a copy of their Maintain Company page from E-Verify to prove that they are enrolled in E-Verify.

5.7 Conflicts. Any conflict in the interpretation of United's policies and this Agreement shall be resolved in accordance with federal and State laws and regulations, including the State Program and Department memos, notices and provider manuals.