ARIZONA ACC MEDICAID AND CHIP PROGRAM
REGULATORY REQUIREMENTS APPENDIX

DOWNSTREAM PROVIDER

THIS ARIZONA ACC MEDICAID AND CHIP REGULATORY REQUIREMENTS APPENDIX (this "Appendix") supplements and is made part of the provider agreement (the "Agreement") between Ear Professionals International Corporation d/b/a EPIC Hearing Healthcare and d/b/a UnitedHealthcare Hearing ("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 State's Medicaid and/or CHIP program (the "State Program") as governed by the State's designated regulatory agencies. Provider has agreed to provide Covered Services to Covered Persons who receive their coverage pursuant to a contract between the State and Health Plan (the "State Contract" as defined herein). The State Contract and applicable State and federal law require that the provisions contained in this Appendix be part of the Agreement. In the event of a conflict between this Appendix and other appendices or any provision of the Agreement, the provisions of this Appendix shall control except with regard to benefit plans outside the scope of this Appendix or unless otherwise required by law. In the event Subcontractor is required to amend or supplement this Appendix as required or requested by 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 State Program and applicable State law, the definitions shall have the meaning set forth under the State Program and applicable State law.

2.1 **Affiliate:** Those entities controlling, controlled by, or under common control with UnitedHealthcare Insurance Company.

2.2 **Arizona Administrative Code (A.A.C.):** State regulations established pursuant to relevant statutes. Referred to in State Contract as "Rules." Arizona Health Care Cost Containment System (AHCCCS) Rules are State regulations which have been promulgated by the AHCCCS Administration, Arizona's Medicaid Agency, and published by the Arizona Secretary of State.

2.3 **Arizona Revised Statutes (A.R.S.):** Laws of the State of Arizona.

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

2.5 **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.

2.6 **Covered Services:** Medically Necessary, cost effective, and federally- and state-reimbursable health care services or products administered by Health Plan and delivered by Health Plan's and/or Subcontractor's network for which a Covered Person is enrolled with Health Plan to receive coverage in accordance with all applicable federal and State laws, regulations and policies, including those listed by reference in attachments to and under the State Contract. Covered Services are described in detail in AHCCCS Rules R9-22 (e.g., Articles 2, 5, and 12), AHCCCS Medical Policy Manual (AMPM), to which Provider must adhere, the AHCCCS Contractor Operations Manual (ACOM), to which Provider must adhere, the State Contract, Section D, Program Requirements, to which Provider must adhere, all of which are incorporated herein by reference, and may be found on the AHCCCS website (http://www.azahcccs.gov). Covered Services are only eligible for reimbursement under AHCCCS Rules and Health Plan's and/or Subcontractor's Payment Policies.

2.7 **Department:** The State agency(ies), or its designated agency, responsible for administering the State Program. For this Appendix, Department is the Arizona Health Care Cost Containment System (AHCCCS), as described in A.R.S. Title 36, Chapter 29, which is responsible for the provision health services to Covered Persons through State Contracts with United. AHCCCS is Arizona's Medicaid State Program, approved by the Centers for Medicare and Medicaid Services as a Section 1115 Waiver Demonstration Program.

2.6 **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 Insurance Company, Arizona Physicians IPA, Inc. or one of its affiliates.

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

2.8 **Primary Care Provider (PCP):** An individual who meets the requirements of A.R.S. § 36-2901, and who is responsible for the management of a Covered Person's health care. A PCP may be a physician defined as a person licensed as an allopathic or osteopathic physician according to A.R.S. Title 32, Chapter 13 or Chapter 17, or a practitioner defined as a physician assistant licensed under A.R.S. Title 32, Chapter 25, or a certified nurse practitioner licensed under A.R.S. Title 32, Chapter 15.

2.9 **Provider:** A hospital, ancillary provider, physician group, individual physician or other health care provider that is qualified and appropriately licensed to provide health care services to individuals enrolled in the State Program and who has entered into an Agreement or is subject to and renders Covered Services under an Agreement for such services.

2.10 **State:** The State of Arizona administering the applicable Medicaid and CHIP program or its designated regulatory agencies.

2.11 **State Contract:** A contract between United and a Department for the purpose of administering and paying for Covered Services to Covered Persons enrolled in the State Program. The State Contract (i.e., YH19-0001; or like successor State Contracts), as amended, includes the AHCCCS

solicitation and all attachments, exhibits and amendments thereto, and the proposal and best and final offer accepted by AHCCCS from Health Plan.

2.12 State Program: AHCCCS Complete Care (ACC) (or Arizona's Medicaid and CHIP Programs).

SECTION 3
PROVIDER REQUIREMENTS

Pursuant to the State Contract and notwithstanding any other provision of this Appendix or the Agreement, Provider agrees to be bound by the provisions contained in the most current, per State Program, Arizona Minimum Subcontract Provisions located on the AHCCCS website at http://www.azahcccs.gov. The Arizona Minimum Subcontract Provisions are incorporated into the Agreement.

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 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) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: (i) 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; (ii) serious impairment to body functions; or (iii) serious dysfunction of any body organ or part.

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

iii) Medically Necessary or Medical Necessity: Covered Service(s) provided by a physician or other licensed practitioner of the healing arts within the scope of practice under State law to prevent disease, disability, or other adverse health conditions or their progression, or to prolong life and as otherwise defined with this Appendix.

iv) Services provided in accordance with 42 CFR Section 438.210(a)(4), as may be amended from time to time, to include that medical or allied care, goods, or services furnished or ordered and which meet the following conditions:

a) Necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain;

b) Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;

c) Consistent with the generally accepted medical standards as determined by the State Program, and not experimental or investigational;

d) Reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available, statewide; and

e) Furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the Provider.

"Medically Necessary" or "Medical Necessity" for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of the appropriate medical care, be effectively furnished more economically on an outpatient basis or by an inpatient Provider of a different type. The fact that Provider has prescribed, recommended or approved medical or allied goods, or services does not, in itself, make such care, goods or services Medically Necessary or a Medical Necessity or a Covered Service.

3.2 Medicaid Eligibility.

http://www.azahcccs.gov/commercial/ProviderRegistration/registration.aspx)

i) Member Benefit Plan Enrollment. A Covered Person must be enrolled in the State Program administered by United from commencement through duration of services.

ii) Provider State Registration:

a) Provider must meet minimum requirements for participation in the State Programs. An AHCCCS Provider Participation Agreement, as defined by AHCCCS, must be signed if Provider is not already an AHCCCS registered provider. Except as otherwise required by law or as otherwise specified in the Agreement--which shall control in the event of a conflict, Provider agrees, AHCCCS Administration fee-for-service provisions referenced in the AHCCCS Provider Participation Agreement located on AHCCCS website (e.g., billing requirements, coding standards, payment rates) are in force between Provider and Health Plan.

b) Because AHCCCS registration is mandatory for consideration for payment by Health Plan for services rendered by managed care providers as well as submission of encounter data to the AHCCCS by Health Plan, Provider must be registered as approved service provider with AHCCCS.

iii) Health Plan is prohibited from paying for an item or service (other than an emergency item or service) for home health care services provided by Provider, unless Provider provides the state with proof of a surety bond as specified in Sections 1861(o)(7) and 1903(i)(18) of the Social Security Act, as verified via AHCCCS Provider Registration.

3.3 Provider Identification Number. Provider must be registered as an approved service provider with AHCCCS and must have a National Provider Identifier (NPI) (if eligible for a NPI).

3.4 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/administrative guide.

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

3.6 Panel Capacity. Provider shall cooperate to resolve any patient capacity issues, including where Health Plan, Subcontractor, or AHCCCS determine that Provider's panel size must be adjusted for Provider(s) to meet AHCCCS appointment and clinical performance standards.

3.7 Hold Harmless. Except for applicable cost-sharing requirements under the State Contract, Provider shall look solely to Health Plan 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 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 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.

3.8 Indemnification. To the fullest extent permitted by law, Provider shall defend, indemnify, save and hold harmless the State of Arizona, and its departments, agencies, boards, commissions, universities, officers, officials, agents, and employees (hereinafter referred to as "Indemnitee") from and against any and all claims, actions, liabilities, damages, losses, or expenses (including court costs, attorneys' fees, and costs of claim processing, investigation and litigation) (hereinafter referred to as "Claims") for bodily injury or personal injury (including death), or loss or damage to tangible or intangible property caused, or alleged to be caused, in whole or in part, by the negligent or willful acts or omissions of Provider or any of its owners, officers, directors, agents, employees or subcontractors. This indemnity includes any claim or amount arising out of or recovered under the Workers' Compensation Law or arising out of the failure of Provider to conform to any Federal, State or local law, statute, ordinance, rule, regulation or court decree. It is the specific intention of the parties that the Indemnitee shall, in all instances, except for Claims arising solely from the negligent or willful acts or omissions of the Indemnitee, be indemnified by Provider from and against any and all claims. It is agreed that Provider will be responsible for primary loss investigation, defense and judgment costs where this indemnification is applicable. In consideration of the award of this contract, Health Plan and/or Subcontractor agrees to waive all rights of subrogation against the State of Arizona, its officers, officials, agents and employees for losses arising from the work performed by the Provider for the State of Arizona.

3.9 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 Health Plan delegates credentialing to Provider, Health Plan

will provide monitoring and oversight and Provider shall ensure that all licensed medical professionals are credentialed in accordance with Health Plan's and the State Contract's credentialing requirements.

3.10 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.

By signing this subcontract, Provider certifies that it has not engaged in any violation of the Medicare Anti-Kickback statute (42 USC §§1320a-7b) or the "Stark I" and "Stark II" laws governing related-entity referrals (PL 101-239 and PL 101-432) and compensation there from. If Provider provides laboratory testing, it certifies that it has complied with 42 CFR 411.361 and has sent to AHCCCS simultaneous copies of the information required by that rule to be sent to the Centers for Medicare and Medicaid Services.

3.11 Subcontracts. If Provider subcontracts or delegates any functions of the Agreement, in accordance with the terms of the Agreement, the subcontract or delegation must be in writing and include all of the requirements of this Appendix, applicable requirements of the State Contract, and applicable laws and regulations. Provider further agrees to promptly amend its agreements with such subcontractors, in the manner requested by Health Plan, to meet any additional State Program requirements that may apply to the services. Provider agrees that, prior to execution of the Agreement, it evaluated its subcontractor's ability to perform any duties delegated to Provider under the Agreement. Any delegated duties and reporting responsibilities shall be in compliance of the State Contract and set forth in the Agreement or other written delegation agreement or addendum between the parties. As applicable, Health Plan's local CEO retains the authority to direct and prioritize any delegated State Contract requirements.

3.12 Records.

Provider acknowledges and agrees that the Department, the U.S. Department of Health and Human Services 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 shall furnish records requested by authorized state personnel or Health Plan or its authorized representative at no charge.

Provider shall maintain books and records relating to covered services and expenditures including reports to Health Plan and Department and working papers used in the preparation of reports to Health Plan and Department. Provider shall comply with all specifications for record keeping established by Health Plan and Department. All books and records shall be maintained to the extent and in such detail as required by Health Plan and Department rules and policies. Records shall include but not be limited to financial statements, records relating to the quality of care, medical records, prescription files and other records specified by Health Plan or Department. Provider agrees to make available at its office at all reasonable times during the term of the Agreement and the period set forth in the following paragraphs, any of its records for inspection, audit or reproduction by any authorized representative of Health Plan, Department, State or federal government.

Provider shall preserve and make available, at no cost, all records for a period of 10 years from the date of final payment under this contract unless a longer period of time is required by law. For retention of patient medical records, Provider shall ensure compliance with A.R.S. §12-2297 which provides, in part, that a health care provider shall retain patient medical records according to the following:

i) If the patient is an adult, the provider shall retain the patient medical records for at least 10 years after the last date the adult patient received medical or health care services from that provider.

ii) If the patient is under 18 years of age, the provider shall retain the patient medical records either for at least three years after the child's eighteenth birthday or for at least 10 years after the last date the child received medical or health care services from that provider, whichever date occurs later.

In addition, Provider shall comply with the record retention periods specified in HIPAA laws and regulations, including, but not limited to, 45 CFR 164.530(j)(2).

If this contract is completely or partially terminated, the records relating to the work terminated shall be preserved and made available, at no cost, for a period of 10 years from the date of any such termination. Records which relate to grievances, disputes, litigation or the settlement of claims arising out of the performance of this contract, or costs and expenses of this contract to which exception has been taken by AHCCCS, shall be retained by Provider for a period of 10 years after the date of final disposition or resolution thereof unless a longer period of time is required by law.

3.13 Government Audit; Investigations. Provider acknowledges and agrees that the State, CMS, the Office of Inspector General, the Comptroller General, and the U.S. Department of Health and Human Services and their designees or their authorized representatives shall at any time have the right to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services provided under the terms of the State Contract and any other applicable rules, including the right to inspect and audit any books, records contracts, documents, computers or other electronic systems of Provider and its subcontractors, and the right to inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted. The right to audit under this section exists for 10 years from the end date of the State Contract or from the date of completion of any audit, whichever is later. There shall be no restrictions on the right of the State or federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness or timeliness of services provided pursuant to the State Contract and the reasonableness of their costs.

Provider shall comply with all applicable Department Rules and Audit Guide relating to the audit of the Provider's records and the inspection of Provider's facilities. If the Provider is an inpatient facility, Provider shall file uniform reports and Title XVIII and Title XIX cost reports with Department.

3.14 Privacy; Confidentiality.

i) 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, 42 CFR 438.6 (if applicable), and A.A.C. R9-22-512, as may be amended from time to time.

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

iii) 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 Health Plan and/or Subcontractor 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 Health Plan and/or Subcontractor 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 Health Plan and/or Subcontractor and the Department to ensure that the breach has been mitigated and reporting requirements, if any, complied with.

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:

i) Title VI of the Civil Rights Act of 1964; title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; Americans with Disabilities Act; section 1557 of the Patient Protection and Affordable Care Act; and their implementing regulations, as may be amended from time to time.

ii) All relevant federal and State statutes, regulations and orders related to equal opportunity in employment, including but not limited to compliance with E.O. 11246, "Equal Employment Opportunity," as amended by E.O. 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and as supplemented by regulations

at 41 CFR part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor."

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

iv) As applicable, all laws regarding safety, unemployment insurance, disability insurance and workers' compensation.

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 438.3, 42 CFR 422.208, and 42 CFR 422.210, as may be amended from time to time. Neither Health Plan and/or Subcontractor 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.

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

i) <u>Prohibition on Use of Federal Funds for Lobbying</u>: 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) <u>Disclosure Form to Report Lobbying</u>: 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.

i) By signing the Agreement, Provider certifies to the best of Provider's knowledge and belief that neither it nor any of its employees, principals, nor any providers, subcontractors or consultants or persons with an ownership or controlling interest in the Provider (an owner

including the Provider himself or herself), or an agent or managing employee of the Provider, with whom Provider contracts and who are providing items or services that are significant and material to Provider's obligations under the Agreement is:

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.

ii) Provider is obligated under 42 CFR §1001.1901(b) to screen all employees, contractors, and/or subcontractors initially and on an ongoing monthly basis 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 to provide items or Covered Services 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 any state or federal exclusion lists. 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.azahcccs.gov/fraud/exclusions.asp. Federal and State exclusion databases must be reviewed monthly to ensure that no employee or contractor has been excluded. Subcontractor will terminate the Agreement immediately and exclude from its network any provider who has been terminated from the Medicare, Medicaid or CHIP program in any state. Subcontractor may also terminate the Agreement if Provider or Provider's owners, agents, or managing employees are found to be excluded on the state or federal exclusion list.

3.19 Disclosure. Provider must be screened and enrolled into the State's Medicaid or CHIP program, as applicable, and submit disclosures to the Department on ownership and control, significant business transactions, and persons convicted of crimes, including any required criminal background checks, in accordance with 42 C.F.R. §§ 455.100 through 455.106, 42 CFR 436 and SMDL09-001 and shall provide information upon request. 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 C.F.R. § 455.105. Additionally, Provider must cooperate with the submission of fingerprints upon a request from the Department or CMS in accordance with 42 CFR 455.434. As defined in the State Contract, a "Change in Organizational Structure of an Administrative Services Subcontractor" shall require a contract amendment and prior approval by AHCSS. If a "Change in Organizational Structure is related to a Contractor's Management Services Agreement," to the extent management of all or substantially all plan functions has been delegated to meet State Contract requirements, prior approval of the State or Department is required.

3.20 Cultural Competency and Access. Provider shall participate in Subcontractor'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 provide physical access, reasonable accommodations, and accessible equipment for Covered Persons with physical or mental disabilities.

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 Subcontractor to submit to the State Program for prior approval.

3.22 Fraud, Waste and Abuse Prevention. If Provider discovers, or is made aware, that an incident of suspected fraud or abuse has occurred, Provider must report the incident to AHCCCS, Office of the Inspector General (AHCCCS-OIG) immediately within one business day and to Health Plan and/or Subcontractor. Additionally:

i) Provider shall cooperate fully with Health Plan and/or Subcontractor'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.

ii) In accordance with Health Plan and/or Subcontractor's policies and the Deficit Reduction Act of 2005 (DRA), Provider shall have written policies for its employees, contractors or agents that: (i) 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; (ii) 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; (iii) reference state laws pertaining to civil or criminal penalties for false claims and statements; and (iv) 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.

iii) Provider agrees to abide by the Medicaid laws, regulations, 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 Health Plan and/or Subcontractor 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 and exclusion

screening), and is conditioned on the Provider's compliance with all applicable conditions of participation in Medicaid. Provider understands and agrees that each claim the Provider submits to Health Plan and/or Subcontractor constitutes a certification that the Provider has complied with all applicable Medicaid laws, regulations and program instructions in connection with such claims and the services provided therein. Provider's payment of a claim may be temporarily suspended if the State or Health Plan and/or Subcontractor 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. Health Plan and/or Subcontractor 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 Health Plan and/or Subcontractor 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.

3.23 Data; Reports. Provider shall timely submit all reports and clinical information required by Health Plan and/or Subcontractor, including child health check-up reporting, if applicable. Provider shall cooperate with and release to Health Plan and/or Subcontractor any information necessary for Health Plan and/or Subcontractor 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 Health Plan and/or Subcontractor, in the format specified by Health Plan and/or Subcontractor 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 Health Plan and/or Subcontractor and the State. Data must be provided at the frequency and level of detail specified by Health Plan and/or Subcontractor or the State. By submitting data to Health Plan and/or Subcontractor, Provider represents and attests to Health Plan and/or Subcontractor and the State that the data is accurate, complete and truthful, and upon Health Plan and/or Subcontractor'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 Insurance Requirements.

i) 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 Health Plan and/or Subcontractor pursuant to the Agreement or as required under the State Contract.

ii) Provider shall maintain insurance requirements at not less than the minimums stated within Department's most current Minimum Subcontractor Provisions regulatory insurance requirements, per State Program, incorporated by reference to this Appendix (located on the AHCCCS website at http://www.azahcccs.gov) and which must be in effect upon services rendered to Covered Persons. For providers working with children or vulnerable adults as defined by A.R.S. §46-451(A)(9), the provider shall obtain insurance as outlined below pursuant to the Minimum Subcontractor Provisions regulatory insurance requirements. For any agreement valued at less than $50,000.00 for the entire term of the agreement, Provider is required to maintain insurance, at a minimum, as specified in "29.2

Standard Professional Service Contract – Working with Children and/or Vulnerable Adults - Under $50,000" subsection. For all other agreements, the provider is required to maintain insurance, at a minimum, as specified in "29.1 Standard Professional Service Contract - Working with Children and/or Vulnerable Adults" subsection.

iii) Provider shall furnish to Health Plan and/or Subcontractor, upon written request, Provider's certificates of insurance. The certificates for each insurance policy must be signed by a person authorized by that insurer to bind coverage on its behalf. Failure to maintain the insurance policies as required by this Agreement or as required under the State Contract., or to provide evidence of renewal, is a material breach of the Agreement.

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 Health Plan and/or 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. If Provider is a nursing facility Provider shall ensure that temporary nursing care registry personnel, including Nurse Aides, are properly certified and licensed before caring for members, in accordance with 42 C.F.R. § 483.75(e) 3 and (g) 2. Provider shall ensure these registry personnel are fingerprinted as required by A.R.S. §36-411.

3.26 **Quality; Utilization Management.** Pursuant to any applicable provider manual/administrative guide and related protocols, or as elsewhere specified under the Agreement, Provider agrees to cooperate with Health Plan and/or Subcontractor'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 Health Plan and/or Subcontractor 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 Health Plan and/or Subcontractor 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. Provider shall develop, maintain and use a system for prior authorization and utilization review that is consistent with Department's rules and policies. Provider shall comply with 42 CFR Part 456, as specified in AMPM Chapter 900 and 1000.

3.27 **Transition of Covered Persons.** Provider shall cooperate with Health Plan and/or Subcontractor 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.

3.28 **Continuity of Care/Treatment.** Provider shall cooperate with Health Plan and/or Subcontractor 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 Health Plan and/or Subcontractor terminates during the course of a Covered Person's treatment by Provider.

3.29 **Termination.** AHCCCS may, by written notice to Provider, terminate this Agreement if it is found, after notice and hearing by the State, that gratuities in the form of entertainment, gifts, or otherwise were offered or given by Provider, or any agent or representative of Provider, to any officer or employee of the State with a view towards securing a contract or securing favorable treatment with respect to the awarding, amending or the making of any determinations with respect to the performance of Provider; provided, that the existence of the facts upon which the state makes such findings shall be in issue and may be reviewed in any competent court. If this Agreement is terminated under this section, AHCCCS shall be entitled to a penalty, in addition to any other damages to which it may be entitled by law, and to exemplary damages in the amount of three times the cost incurred by Provider in providing any such gratuities to any such officer or employee.

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

This Agreement is voidable and subject to immediate termination by AHCCCS upon Provider becoming insolvent or filing proceedings in bankruptcy or reorganization under the United States Code, or upon assignment or delegation of this Agreement without AHCCCS' prior written approval.

3.30 **Authorization.** Provider shall obtain any necessary authorization from Health Plan and/or Subcontractor for services provided to eligible and/or enrolled Covered Persons consistent with Health Plan and/or Subcontractor's policies and the requirements of the State Program. Such authorization is not a guarantee of payment and Health Plan and/or Subcontractor may rescind an authorization and deny or recoup payments if one or more of the following occurs: (a) service recipient was not eligible for coverage; (b) services are not covered or exceed the benefit limits; (c) where applicable, the Provider is not registered with the State Medicaid agency; (d) claims do not comply with Health Plan and/or Subcontractor's clean claims requirements; and/or (e) services were the subject of fraud, waste or abuse. If prior authorization was given for an inpatient hospital admission, a specific service, or level of care but subsequent medical review indicates that the admission, the service, or level of care was not medically appropriate, Health Plan and/or Subcontractor shall adjust the claim payment.

3.31 **Advance Directives.** Providers that are hospitals, nursing facilities, home health agencies, hospices, or organizations responsible for providing personal care, as well as PCPs that contract with any of the above entities, shall comply with federal (i.e. 42 CFR Part 49, subpart I, 42 CFR § 417.436(d), 42 CFR § 422.128, and 42 CFR 438.3(i)) and State law regarding advance directives for adult Covered Persons. Such requirements include the following:

i) Maintaining written policies that address the rights of adult Covered Persons to make decisions about medical care, including the right to accept or refuse medical care, and the right to execute an advance directive. If the Provider has a conscientious objection to carrying out an advance directive, it must be explained in the policies. A health care provider is not prohibited from making such objection when made pursuant to A.R.S. § 36-3205(C)(1).

ii) Providing written information to adult Covered Persons regarding each individual's rights under State law to make decisions regarding medical care, and the Provider's written policies concerning advance directives (including any conscientious objections).

iii) Documenting in the Covered Person's medical record whether or not the adult Covered Person has been provided the information and whether an advance directive has been executed. Providers that are hospitals, nursing facilities, home health agencies, hospices, or organizations responsible for providing personal care shall make an effort to provide a copy of a Covered Person's advance directive, or documentation of refusal, to the Covered Person's PCP for inclusion in the Covered Person's medical record.

iv) Not discriminating against a Covered Person because of his or her decision to execute or not execute an advance directive, and not making it a condition for the provision of care.

v) Providing education to staff on issues concerning advance directives, including notification of direct care providers of services, such as home health care and personal care, of any advance directives executed by Covered Persons to whom they are assigned to provide services.

3.32 Claims.

i) Compensation. Provider shall be compensated in accordance with the Agreement.

ii) Submission. Initial claim submission shall occur within the deadlines set forth in the Agreement. Unless a shorter period is stated otherwise in the Agreement, which shall control, Health Plan and/or Subcontractor shall not pay claims for Covered Services:

a) that are initially submitted more than six months after the date of the service for which payment is claimed or after the date that Covered Person's eligibility is posted, whichever date is later, or

b) that are submitted as clean claims more than twelve months after the date of service for which payment is claimed or after the date that eligibility is posted, whichever date is later.

iii) Re-submissions. Provider shall submit all claim appeals/re-submissions for Covered Services in writing in accordance with address listed on Provider's remit from Health Plan and/or Subcontractor and in applicable provider manual/administrative guide, unless Provider is appealing an action on behalf of a member in which event Provider shall follow member appeals rights in applicable provider manual/administrative guide and under R9-34-201 et seq.

iv) Encounters. Provider shall comply with Health Plan and/or Subcontractor's requirements for accurate and timely reporting of encounter data and submission of claims, as set forth in the Agreement, applicable provider manual/administrative guide, and protocols, policies and procedures provided or made available to Provider. Provider shall submit timely, complete, and accurate encounter data to Health Plan and/or Subcontractor in accordance with the requirements of Health Plan and/or Subcontractor and 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 Health Plan and/or Subcontractor and State requirements. By submitting encounter data to Health Plan and/or Subcontractor, Provider represents to Health Plan and/or Subcontractor that the data is accurate, complete and truthful, and upon Health Plan and/or Subcontractor's request Provider shall certify in writing, that the data is accurate, complete, and truthful, based on Provider's best knowledge, information and belief.

v) Capitated Risk; Encounter Data/"Claims of Payment:" For only those arrangements under the Agreement in which Health Plan and/or Subcontractor and Provider have a capitated arrangement/risk sharing arrangement, if Provider does not bill Health Plan and/or Subcontractor (e.g., Provider is capitated), Provider's encounter data that is required to be submitted to Health Plan and/or Subcontractor pursuant to the Agreement and this Appendix is defined for these purposes as a "claim for payment." Provider's provision of any service results in a "claim for payment" regardless of whether there is any intention of payment. All said claims shall be subject to review under any and all fraud and abuse statutes, rules and regulations, including but not limited to A.R.S. §§ 36-2918.

3.33 Claim Disputes. The result of the Covered Person claim dispute process shall be binding on Provider, per State Medicaid Grievance System requirements. For this Appendix, State Medicaid Grievance System means Arizona Administrative Code Title 9 Chapter 34 et. seq.

i) Provider may wish to file a claim dispute to maintain its regulatory afforded rights, e.g., based on a claim denial; for dissatisfaction with a claim payment; or for recoupment action by Health Plan and/or Subcontractor. Provider may challenge the claim denial or adjudication by filing a formal claim dispute with Health Plan and/or Subcontractor. Pursuant to AHCCCS guidelines and state rules, all claim disputes challenging claim payments, denials or recoupments must be filed in writing no later than 12 months from the date of services, 12 months after the date of eligibility posting or within 60 days after the payment, denial or recoupment of a timely claim submission, whichever is later. The claim dispute must be referenced/titled as such, i.e., "claim dispute" and state with particularity the factual and legal basis for the relief requested, along with all supporting documentation such as claims, remits, medical review sheets, medical records, correspondence, etc. Incomplete submissions or those which do not meet the criteria for a claim dispute will be denied.

ii) If Provider disagrees with the claim dispute decision at issue, Provider may submit its written request for a state fair hearing within 30 days of receipt of Provider's claim dispute notice of decision (claim dispute at issue). Provider's request for state fair hearing must include the claim dispute number from the notice of decision, the Covered Person's name, and be clearly identified as a request for state fair hearing.

iii) All claim disputes must be submitted in writing in accordance with address listed on Provider's remit from Health Plan and/or Subcontractor and in applicable provider manual/administrative guide.

3.34 Primary Care Physicians (PCPs). This provision applies to Providers who are PCPs. When a PCP has initiated medication management services for a Covered Person to treat a behavioral health disorder and it is subsequently determined by the PCP or Health Plan and/or Subcontractor that the Covered Person should be transferred to a Regional Behavioral Health Authority (RBHA) prescriber for evaluation and/or continued medication management services, the PCP shall

cooperate with Health Plan and/or Subcontractor in coordinating the transfer of the Covered Person's care to the RBHA. Provider agrees that, the Integrated RBHA--entity contracted with ADHS to provide, manage and coordinate all medically necessary behavioral healthcare services for Title XIX eligible adults and all medically necessary physical health services for individuals with serious mental illness--will provide the full continuum of care including all outpatient and inpatient medical and behavioral health care as well as supportive services, per Member's eligibility and Covered Services.

3.35 Coordinate Benefits. In coordination with Medicaid Eligibility provision of this Appendix, Provider agrees, as a condition precedent to billing Health Plan and/or Subcontractor, to exhaust any entitlement to payment from applicable third party sources, such as member's (i) primary insurance, or (ii) Medicare insurance, or (iii) workers' compensation, or (iv) tortfeasors and insurers providing coverage to tortfeasors, so that any costs for services payable by Health Plan and/or Subcontractor are cost avoided/recovered from any available third party payor.

3.36 Tax Obligations. Provider shall be fully responsible for all tax obligations, workers' compensation insurance, and all other applicable insurance coverage obligations that arise under the Agreement, for itself and its employees. AHCCCS shall have no responsibility or liability for any such taxes or insurance coverage.

3.37 Certification of Truthfulness of Representation. By signing this Agreement, Provider certifies that all representations set forth herein are true to the best of its knowledge.

3.38 Clinical Laboratory Improvement Amendments of 1988. The Clinical Laboratory Improvement Amendment (CLIA) of 1988 requires laboratories and other facilities that test human specimens to obtain either a CLIA Waiver or CLIA Certificate in order to obtain reimbursement from the Medicare and Medicaid (AHCCCS) programs. In addition, they must meet all the requirements of 42 CFR 493, Subpart A.

To comply with these requirements, AHCCCS requires all clinical laboratories to provide verification of CLIA Licensure or Certificate of Waiver during the provider registration process. Failure to do so shall result in either a termination of an active provider ID number or denial of initial registration. These requirements apply to all clinical laboratories.

Pass-through billing or other similar activities with the intent of avoiding the above requirements are prohibited. Provider may not reimburse providers who do not comply with the above requirements.

3.39 Federal Immigration and Nationality Act. Provider shall comply with all Federal, State and local immigration laws and regulations relating to the immigration status of their employees during the term of the contract. Further, Provider shall flow down this requirement to all subcontractors utilized during the term of the contract. The Department shall retain the right to perform random audits of Health Plan and/or Subcontractor and Provider records or to inspect papers of any employee thereof to ensure compliance. Should the Department determine that Health Plan and/or Subcontractor and/or any Provider be found noncompliant, the Department may pursue all remedies allowed by law, including, but not limited to; suspension of work, termination of the contract for default and suspension and/or debarment of the Provider.

3.40 Non-Discrimination Requirements. Provider shall comply with State Executive Order No. 99-4, which mandates that all persons, regardless of race, color, religion, gender, national origin or

political affiliation, shall have equal access to employment opportunities, and all other applicable Federal and State laws, rules and regulations, including the Americans with Disabilities Act and Title VI. Provider shall take positive action to ensure that applicants for employment, employees, and persons to whom it provides service are not discriminated against due to race, creed, color, religion, sex, national origin or disability. Provider will not discriminate against Covered Persons on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability and will not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin, sex, sexual orientation, gender identity, or disability.

3.41 **Standards of Conduct.** Provider will perform services for members consistent with the proper and required practice of medicine and must adhere to the customary rules of ethics and conduct of its appropriate professional organization including, but not limited to, the American Medical Association and other national and state boards and associations or health care professionals to which they are subject to licensing, certification, and control.

3.42 **Warranty of Services.** Provider, by execution of this subcontract, warrants that it has the ability, authority, skill, expertise and capacity to perform the services specified in this contract.

3.43 **Business Continuity Recovery Plan.** If Health Plan and/or Subcontractor delegates any State Contract administrative services to Provider, Provider shall develop and maintain a Business Continuity and Recovery Plan (referred to herein as the “Plan”) to ensure that essential delegated functions continue during emergencies. Provider shall ensure that the Plan addresses critical services and factors that could cause disruption as well as timelines for resuming any disrupted critical services following an emergency. In addition, Provider shall: (i) review and test the Plan at least annually; and (ii) train their employees on implementation of the Plan in the event of emergencies.

“Administrative services” as used in this section means core State Contract functions including but not limited to: claims processing; credentialing; including primary source verification; management services; member/provider services; utilization review; grievance and appeals; quality care management; and any other identified critical services. If Provider is delegated administrative services, Provider must ensure that its Plan complies with the requirements set forth in the AHCCS Contractor Operations Manual, Section 104 available on the State’s AHCCCS website.

https://www.azahcccs.gov/shared/ACOM/Chapter100.html

3.44 **Compliance with Medicaid Laws and Regulations.** Provider agrees to abide by the Medicaid laws, regulations and program instructions to the extent applicable to Provider in Provider’s performance of the Agreement. Provider understands that payment of a claim by Health Plan and/or Subcontractor or the State is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited to, federal requirements on fraud, waste and abuse, disclosure, debarment, termination and exclusion screening), and is conditioned on the Provider’s compliance with all applicable conditions of participation in Medicaid. Provider understands and agrees that each claim the Provider submits to Health Plan and/or Subcontractor constitutes a certification that the Provider has complied with all applicable Medicaid laws, regulations and program instructions in connection with such claims and the services provided therein. Provider’s payment of a claim will be denied if Provider is terminated or excluded from participation in federal healthcare programs. Provider’s payment of a claim may be temporarily suspended if the State or Health Plan and/or Subcontractor

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. Health Plan and/or Subcontractor 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 Health Plan and/or Subcontractor 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.

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

3.46 Health Records. Provider agrees to cooperate with Health Plan and/or Subcontractor 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.

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

3.48 Member Communications. If Health Plan and/or Subcontractor delegates any State Contract administrative services to Provider, Provider shall include Health Plan and/or Subcontractor's name on all Covered Person communications and comply with member notification requirements outlined in ACOM Policy 404.

3.49 Performance Standards. If Health Plan and/or Subcontractor delegates any State Contract administrative services to Provider, Provider shall meet any performance standards applicable to the delegated services as mandated by the Department.

3.50 Opioid Requirements. Provider shall adhere to the requirements of the Arizona Opioid Epidemic Act SB1001/HB2001.

SECTION 4
SUBCONTRACTOR REQUIREMENTS

4.1 Prompt Payment. Subcontractor 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 Subcontractor otherwise requests assistance from Provider, Subcontractor will be responsible for third party collections in accordance with the terms of the State Contract.

4.2 No Incentives to Limit Medically Necessary Services. 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.

4.3 Provider Discrimination Prohibition.

i) In accordance with 42 CFR 438.12 and 438.214(c), Subcontractor shall not discriminate with respect to participation, reimbursement, or indemnification of a provider who is acting within the scope of Provider's license or certification under applicable State law, solely on the basis of such license or certification. This provision shall not be construed as prohibiting 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 Subcontractor that are designed to maintain quality of care practice standards and control costs.

ii) Subcontractor shall not discriminate against Provider for serving high-risk Covered Persons or if Provider specializes in conditions requiring costly treatments. Agreements shall not contain compensation terms that discourage Providers from serving any specific eligibility category; cost sharing requirements designed towards specific eligibility categories are excepted.

iii) Subcontractor shall not prohibit Provider from providing services for any other AHCCCS contractor.

4.4 Communications with Covered Persons. Subcontractor 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 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.

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.

4.5 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 Subcontractor's reasonable judgment Provider's performance under the Agreement is inadequate. 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, including an immediate termination clause in the event of a risk to Covered Person's health or safety.

4.6 Update. In the event of a material modification to the AHCCCS Minimum Subcontract Provisions within the State Contract, Subcontractor shall issue a notification of the material modification to

Provider within 30 days of the published material modification to which Provider agrees to be bound by as referenced within this Appendix.

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 manual/administrative guide, and protocols, policies and procedures that Health Plan and/or Subcontractor has provided or made available to Provider. The applicable provisions of the State Contract are incorporated into the Agreement by reference. The following documents, and any subsequent amendments, modifications, and supplements adopted by or affecting Health Plan and/or Subcontractor or State during the term of the Agreement, are incorporated herein by reference and made a part of the Agreement: all AHCCCS Minimum Subcontract Provisions, guidelines, policies and manuals and Subcontractor policies and procedures directly related to Provider's provision of services and items. Nothing in the Agreement relieves Subcontractor 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.** Health Plan and/or 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, Health Plan and/or Subcontractor shall identify to Provider any deficiencies or areas for improvement mandated under the State Contract and Provider and Health Plan and/or Subcontractor shall take appropriate corrective action. Provider shall comply with any corrective action plan initiated by Health Plan and/or Subcontractor 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 Health Plan and/or Subcontractor and Provider practice and/or the performance standards established under the State Contract.

5.3 **Health Care Acquired/Preventable Conditions.** Health Plan and/or Subcontractor and Provider acknowledge and agree that Health Plan and/or Subcontractor is prohibited from making payments to Provider for the provision of medical assistance for health care-acquired conditions and other provider-preventable conditions as may be identified by the Department. (2702 of the Patient Protection and Affordable Care Act - Federal Register / Vol. 76, No. 108 / Monday, June 6, 2011; 42 CFR 438.6(h), 42 CFR 422.208 and 422.210) As a condition of payment, Provider shall identify and report to Health Plan and/or Subcontractor any provider preventable conditions in accordance with 42 CFR §§ 434.6(a)(12), 438, including but not limited to § 438.3(g), and § 447.26.

5.4 **AHCCCS Controls Enrollment.** The parties acknowledge and agree that AHCCCS is responsible for enrollment, re-enrollment and disenrollment of Covered Persons.

5.5 **Steerage Prohibition.** Health Plan and/or Subcontractor or Provider may provide persons eligible for the State Program with factual information, but are prohibited from recommending or steering

such persons in their selection of an AHCCCS-contracted managed care organization or similar entity.

5.6 Without Cause Termination Notice. The term of the Agreement, including beginning and end dates and procedures for extension, termination and renegotiation, shall be as set forth in the Agreement, provided that Health Plan shall give hospitals and provider groups at least ninety (90) days' notice prior to terminating the Agreement without cause.

5.7 Assignment and Delegation of Rights and Responsibilities. No payment due to Provider under this Agreement may be assigned without the prior approval of Health Plan and/or Subcontractor. No assignment or delegation of the duties of this Agreement shall be valid unless prior written approval is received from Health Plan and/or Subcontractor.

5.8 Awards of Other Subcontracts. The Department and/or Health Plan and/or Subcontractor may undertake or award other contracts for additional or related work to the work performed by Provider who shall fully cooperate with such other plans, providers or state employees. Provider shall not commit or permit any act which will interfere with the performance of work by any other health plan, provider or state employee.

5.9 Contract Claims and Disputes. Contract claims and disputes arising under A.R.S. Title 36, Chapter 29 shall be adjudicated in accordance with AHCCCS Rules, A.R.S. §36-2901 et seq. (for ACC) and A.R.S. §36-2931 et seq. (for ALTCS).

5.10 E-Verify Requirements. In accordance with A.R.S. §41-4401, the Health Plan and/or Subcontractor and Provider warrant compliance with all Federal immigration laws and regulations relating to employees and warrants its compliance with Section A.R.S. §23-214, Subsection A.

5.11 Off-Shore Performance of Work Prohibited. Any services that are described in the specifications or scope of work that directly serve the State of Arizona or its clients and involve access to secure or sensitive data or personal client data shall be performed within the defined territories within the borders of the Health Plan and/or Subcontractor States. Unless specifically stated otherwise in specifications, this definition does not apply to indirect or "overhead" services, redundant back-up services or services that are incidental to the performance of the contract. This provision applies to work performed by Provider at all tiers.

5.12 Severability. If any provision of these subcontract terms and conditions is held invalid or unenforceable, the remaining provisions shall continue valid and enforceable to the full extent permitted by law.