RHODE ISLAND MEDICAID PROGRAM

REGULATORY REQUIREMENTS APPENDIX

DOWNSTREAM PROVIDER

THIS RHODE ISLAND MEDICAID PROGRAM 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 heath care services that Provider provides directly to Covered Persons through Health Plan's (as defined herein) products or benefit plans under the State of Rhode Island's Medicaid managed care programs (collectively 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 Health Plan and the State (the "State Contract," as defined herein). 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, the definitions shall have the meaning set forth under the State Program.

2.1 **Agreement:** An executed contract between Subcontractor and Provider for the provision of Covered Services to persons enrolled in a State Program.

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

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

2.4 **Department(s):** The Rhode Island Department of Human Services and the Rhode Island Executive Office of Health and Human Services.

2.5 **State:** The State of Rhode Island or its designated regulatory agencies.

2.6 **State Contract:** Health Plan's contract with the Rhode Island Department of Human Services for the purpose of providing and paying for Covered Services to Covered Persons enrolled in the State Program.

2.7 **State Program:** The Rhode Island Medicaid program(s) developed and administered by the State. For purposes of this Appendix, State Program may refer to the State agency(ies) responsible for administering the applicable State Program.

SECTION 3
PROVIDER REQUIREMENTS

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

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

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

(b) 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.

(c) Medically Necessary or Medical Necessity: Medical, surgical, or other services required for the prevention, diagnosis, cure, or treatment of a health related condition including such services necessary to prevent a decremental change in either medical or mental health status. Medically necessary services must be provided in the most cost effective and appropriate setting and shall not be provided solely for the convenience of the Covered Person or 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 or CHIP Participation.** Provider must be enrolled with the State as a Medicaid or CHIP provider, as applicable to participate in Health Plan's Medicaid or CHIP network. Upon notification from the State that Provider's enrollment has been denied or terminated, Subcontractor and Health Plan must terminate Provider immediately and will notify affected Covered Persons that Provider is no longer participating in the network. Subcontractor and Health Plan will exclude from its network any provider who is on the State's exclusion list or has been terminated or suspended from the Medicare, Medicaid or CHIP program in any state.

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

3.4 **Hours of Operation; Appointments.** Provider shall offer hours of operation that are no less than the hours of operation offered to commercial beneficiaries or comparable to Medicaid fee-for-service if Provider serves only Medicaid beneficiaries. As applicable, Provider will make Covered Services available 24 hours a day, 7 days a week when medically necessary.

3.5 **Mainstreaming.** Provider shall accept all Covered Persons for treatment. If Provider refuses to accept a Covered Person for treatment, Provider may not accept non-Covered Persons for treatment and remain in the Subcontractor or Health Plan network. Provider shall not segregate Covered Persons in any way from other persons receiving services from Provider.

3.6 **Hold Harmless.** Except for applicable cost-sharing requirements under the State Contract, Provider shall look solely to Subcontractor or Health Plan, as applicable for payment of Covered Services provided to Covered Persons pursuant to the Agreement and the State Contract and hold the State, the U.S. Department of Health and Human Services and Covered Persons harmless in the event that Subcontractor or Health Plan cannot or will not pay for such Covered Services. The State shall bear no liability (other than liability for making payments required by the State Contract) for paying the valid claims of Subcontractor or Health Plan subcontractors, including Provider and suppliers. In accordance with 42 CFR Part 447.15, as may be amended from time to time, the Covered Person is not liable to Provider for any services for which Subcontractor or Health Plan is liable and as specified under the State's relevant health insurance or managed care statutes, rules or administrative agency guidance. Provider shall not require any copayment or cost sharing for Covered Services provided under the Agreement unless expressly permitted under the State Contract. Provider shall also be prohibited from charging Covered Persons for missed appointments if such practice is prohibited under the State Contract or applicable law. Neither the State, the Department nor Covered Persons shall be in any manner liable for the debts and obligations of Subcontractor or Health Plan and under no circumstances shall Provider, Subcontractor or Health Plan, or any providers used to deliver services covered under the terms of the State Contract, charge Covered Persons for Covered Services. This

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

3.7 **Indemnification.** To the extent applicable to Provider in performance of the Agreement, Provider shall indemnify, defend, protect and hold harmless Subcontractor, Health Plan and the State and any of their officers, agents, and employees from:

(i) Any claims for damages or losses arising from Covered Services rendered by Provider in connection with the performance of the Agreement or the State Contract;

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

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

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

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

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

3.9 **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.

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

3.11 **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. Provider shall retain all records including, as applicable, grievance and appeal records and any other records related to data, information, and documentation for a period of not less than 10 years from the close of the Agreement, or such other period as required by law. If records are under review or audit, they must be retained for a minimum of 10 years following resolution of such action. Prior approval for the disposal of records must be requested and approved by Subcontractor and Health Plan if the Agreement is continuous.

3.12 **Records Access.** Provider acknowledges and agrees that the State, the U.S. Department of Health and Human Services and other authorized federal and state personnel shall have 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.

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, audit 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 records or documents 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.

3.14 **Privacy; HIPAA.** Provider shall comply with all applicable privacy rule, security rule and the operational and informational system requirement provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and associated implementing regulations and shall safeguard information about Covered Persons in accordance with applicable federal and State privacy laws and rules including 42 CFR Part 438.224 and 42 CFR Part 431, Subpart F, as may be amended from time to time. Pursuant to 42 CFR Part 431.305 and HIPAA, and subject to any permitted uses under the Agreement, Provider agrees to maintain the confidentiality of Covered Person's information regarding names and addresses, medical services provided, social and economic conditions or circumstances, Department evaluations of personal information, medical data, including diagnosis and past history of diseases or disability,

and any information received in connection with the identification of legally liable third party resources.

Additionally, Provider agrees to take reasonable steps to ensure the physical security of confidential information under its control, including, but not limited to: fire protection, protection against smoke and water damage, alarm systems, locked files, guards, or other devices reasonably expected to prevent loss or unauthorized removal of manually held data. Provider will inform each of its employees having any involvement with personal data or other confidential information, whether with regard to design, development, operation, or maintenance, of the laws and regulations relating to confidentiality.

3.15 **Return of Confidential Information.** Provider agrees to return all personal data related to the State Contract and furnished pursuant to the Agreement promptly at the request of Subcontractor or Health Plan in whatever form is maintained by Provider. Upon the termination or completion of the Agreement, Provider will not use any such data or any material derived from the data for any purpose not permitted by law and where so instructed by Subcontractor or Health Plan, will destroy such data or material if permitted by law.

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

(a) Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000D et seq.); Title IX of the Education Amendments of 1972 (20 U.S.C. § 1681 et seq.) (regarding education programs and activities); the Age Discrimination Act of 1975; Title 41, Code of Federal Regulations, Chapter 60; Title 20, Code of federal Regulations, Part 741; the Federal Rehabilitation Act of 1973; Executive Order 11758; Section 504 of Title V of the Vocational Rehabilitation Act of 1973, as amended; and Public Law 101-336, the 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.

(b) 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."

(c) 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 Section 306 of the Clean Air Act, 42 U.S.C. § 7401 et seq., Section 508 of the Clean Water Act, 33 U.S.C. § 1368, Executive Order 11738, Environmental Protection Agency Regulations, 40 CFR Part 15, 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.

(d) The United States Department of Health and Human Services regulations found in 45 CFR Parts 80 and 84, and the United States Department of Education implementing regulations (34 CFR Parts 104 and 106), which prohibit discrimination on the basis of race, color, national origin, handicap, or sex, in acceptance for or provision of services, employment, or treatment in educational or other programs or activities.

(e) Stat. 53-1147, the federal "Hatch Act," as amended.

3.17 **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 Parts 417.479, 438.3, 422.208, and 422.210, as may be amended from time to time. Neither Subcontractor, Health Plan nor Provider may make a specific payment directly or indirectly under a PIP to a physician or physician group as an inducement to reduce or limit Medically Necessary services furnished to an individual Covered Person. PIPs must not contain provisions that provide incentives, monetary or otherwise, for the withholding of services that meet the definition of Medical Necessity.

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

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

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

3.19 **Excluded Individuals and Entities.** By signing the Agreement, Provider certifies to the best of Provider's knowledge and belief that neither it nor any of its principals, nor any providers, subcontractors or consultants with whom Provider contracts and who are providing

items or services that are significant and material to Provider's obligations under the Agreement is:

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

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

Provider is obligated to screen its employees and contractors to determine whether any of them have been debarred or excluded from participation in Medicare, Medicaid, CHIP, or any Federal Health Care Programs (as defined in Section 1128B(f) of the Social Security Act). Provider shall not employ or contract with an individual or entity that has been excluded. Provider shall immediately report to Subcontractor any exclusion information discovered. Provider acknowledges and agrees that civil monetary penalties may be imposed against Provider if he or she employs or enters into contracts with excluded individuals or entities to provide items or Covered Services. Provider can search the HHS-OIG website, at no cost, by the names of any individuals or entities. The database is called LEIE and can be accessed at http://www.oig.hhs.gov/fraud/exclusions.asp. 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. Subcontractor and/or Health Plan will terminate the Agreement immediately and exclude from its network any provider who has been terminated from the Medicare, Medicaid or CHIP program in any state. Subcontractor and/or Health Plan may also terminate the Agreement if Provider or Provider's owners, agents, or managing employees are found to be excluded on a State or Federal exclusion list.

3.20 **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 CFR Part 455 Subparts B and E. Provider must submit information related to ownership and control of subcontractors or wholly owned suppliers within 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.

3.21 **Cultural Competency and Access.** Provider shall participate in Subcontractor's, Health Plan's and the State's efforts to promote the delivery of services in a culturally competent manner to all 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 also provide physical access, reasonable accommodations, and accessible equipment for Covered Persons with physical or mental disabilities.

3.22 **Marketing.** As required under State or federal law or the State Contract, and subject to the restrictions noted in *Marketing and Approval of Written Materials Protocols for Medicaid Managed Care Programs*, issued by the State, any marketing materials developed and distributed by Provider as related to the performance of the Agreement (as well as all other written materials Provider produces for dissemination to Covered Persons) must be submitted to Subcontractor and Health Plan to submit to the State Program for approval prior to use. All marketing materials must be written at no higher than a sixth-grade level, in a format and a manner that is easily understood.

3.23 **Fraud, Waste and Abuse Prevention.** Provider shall cooperate fully with Subcontractor's and Health Plan's policies and procedures designed to protect program integrity and prevent and detect potential or suspected fraud, abuse and waste in the administration and delivery of services under the State Contract and shall cooperate and assist the State Program and any other State or federal agency charged with the duty of preventing, identifying, investigating, sanctioning or prosecuting suspected fraud, abuse or waste in State and/or federal health care programs. Provider shall comply with all federal and State requirements regarding Medicaid fraud and abuse, including but not limited to Sections 1124, 1126(b)(1), 1126(b)(2), 1126(b)(3), 1128, 1156, 1892, 1902(a)(68), and 1903(i)(2) of the Social Security Act and Section 40-8.2-2 of the General Laws of Rhode Island.

In accordance with the Deficit Reduction Act of 2005 (DRA), if Provider receives annual Medicaid payments of at least five (5) million dollars (cumulative, from all sources), Provider must 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.

3.24 **Data; Reports.** Provider shall cooperate with and release to Subcontractor and/or Health Plan any information necessary for Subcontractor and/or Health Plan to perform its obligations under the State Contract to the extent applicable to Provider in performance of the Agreement, including the timely submission of reports and information required by Subcontractor and/or Health Plan, in the format specified by Subcontractor, Health Plan and/or the State. Such reports

shall include child health check-up reporting, if applicable, as well as complete and accurate encounter data in accordance with the requirements of Subcontractor and/or Health Plan and the State. Data must be provided at the frequency and level of detail specified by Subcontractor, Health Plan or the State. By submitting data to Subcontractor and/or Health Plan, Provider represents and attests to Subcontractor, Health Plan and the State that the data is accurate, complete and truthful, and upon Subcontractor's and/or Health Plan's request Provider shall certify in writing, that the data is accurate, complete, and truthful, based on Provider's best knowledge, information and belief.

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

3.25 **Claims Information.** Provider shall promptly submit to Subcontractor or Health Plan (as applicable) 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 Subcontractor or Health Plan. Provider understands and agrees that each claim Provider submits to Subcontractor and/or Health Plan constitutes a certification that the claim is true and accurate to the best of Provider's knowledge and belief and that the Covered Services are 1) Medically Necessary and 2) have been provided to the Covered Person prior to submitting the claim.

3.26 **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 Subcontractor, Health Plan or the Department is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited to, federal requirements on fraud, waste and abuse, disclosure, debarment, termination and exclusion screening), and is conditioned on the Provider's compliance with all applicable conditions of participation in Medicaid. Provider understands and agrees that each claim the Provider submits to Subcontractor or Health Plan constitutes a certification that the Provider has complied with all applicable Medicaid laws, regulations and program instructions in connection with such claims and the services provided therein. Provider's payment of a claim will be denied if Provider is terminated or excluded from participation in federal healthcare programs. Provider's payment of a claim may be temporarily suspended if the State, Subcontractor or Health Plan provides notice that a credible allegation of fraud exists and there is a pending

investigation. Provider's payment of a claim may also be temporarily suspended or adjusted if the Provider bills a claim with a code that does not match the service provided. Subcontractor and/or Health Plan performs coding edit procedures based primarily on National Correct Coding Initiative (NCCI) policies and other nationally recognized and validated policies. Provider agrees that it will provide medical records to Subcontractor and/or Health Plan upon its request in order to determine appropriateness of coding. Provider may dispute any temporarily suspended or adjusted payment consistent with the terms of the Agreement.

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

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

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

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

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

3.32 **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 49, subpart I, 42 CFR § 417.436(d), 42 CFR § 422.128, and 42 CFR 438.3(i).

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

3.34 **Health Care Acquired/Preventable Conditions.** Provider agrees that no payment shall be made for the provision of medical assistance for health care acquired conditions and other provider preventable conditions as may be identified by the State. As a condition of payment, Provider shall identify and report to Subcontractor any provider preventable conditions in accordance with 42 CFR Part 438, including but not limited to 438.6(f)(2)(i).

3.35 **Patent or Copyright Infringement.** Provider shall represent that, to the best of its knowledge, none of the software to be used, developed or provided pursuant to this Agreement violates or infringes upon any patent, copyright, or any other right of a third party. If any claim or suit is brought against Subcontractor, Health Plan or the State for the infringement of such patents or copyrights arising from Provider's use of any equipment, materials, computer software and products, or information prepared by or on behalf of Provider, or developed in connection with Provider's performance of the Agreement, then Provider shall, at its expense, defend such claim or suit. Provider shall satisfy any final award for such infringement, through a judgment involving such a claim, suit or by settlement, with Subcontractor and Health Plan's right of approval.

3.36 **Ownership of Data and Reports.** Data, information, and reports collected or prepared directly or indirectly for the State by Provider in the course of performing its duties and obligations under the Agreement shall be deemed to be owned by the State. This provision is made in consideration of Provider's use of public fund in collecting or preparing such data, information, and reports. Nothing contained herein shall be deemed to grant to the State ownership or other rights in Provider's proprietary information systems or technology used in conjunction with the Agreement.

3.37 **CurrentCare Participation.** As a provision of the State's Medicaid program requirements, Provider shall make efforts to enroll as a user of CurrentCare, the free service developed by the Rhode Island healthcare community and run by the Rhode Island Quality Institute. This enrollment shall also include utilization of Hospital Alerts, the real-time application to inform providers when Covered Persons are admitted or discharged from a hospital or emergency department. Such enrollment promotes timely follow-up care to improve outcomes and reduce re-admissions. Additionally, Provider shall participate in Direct Messaging

services within the CurrentCare system which will permit the transmittal of protected health information to known, trusted recipients, over the internet in order to coordinate care. Provider shall also encourage Covered Persons identified by United as high utilizers to enroll in CurrentCare.

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

3.39 **Non-Discrimination.** 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.

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

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

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

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

SECTION 4
ADDITIONAL PROVIDER REQUIREMENTS FOR SPECIFIC ACTIVITIES

4.1 **Primary Care Provider (PCP) Responsibilities.** The PCP must serve as the Covered Person's initial and most important point of interaction within Subcontractor or Health Plan network. As such, PCP responsibilities must include at a minimum:

(a) Serving as the Covered Person's Primary Care Provider;

(b) Making referrals for specialty care and other Medically Necessary services, both in- and out-of-plan;

(c) Maintaining a current medical record for the Covered Person; and

(d) Referring Covered Persons for care management services.

4.2 **Department of Health Laboratory**. As applicable to Provider in performance of the Agreement, Provider must submit to the Rhode Island Department of Health laboratory ("DOH") all specimens for HIV testing and mycobacteria (TB) analysis. All blood lead screening test samples, including venipuncture samples, should be submitted to DOH laboratory for analysis. All non-screening blood lead samples shall be considered diagnostic lead testing and may be sent to any lab licensed by the DOH to perform blood lead analysis. Provider must also submit specimens from suspected cases of measles, mumps, rubella, and pertussis when required by the State to facilitate investigations of outbreaks.

4.3 **Community and Home Health Agencies.** The Rhode Island Medicaid program does not permit payment to legally responsible individuals, as further defined below, for the provision of any health care related services that the legally responsible individual would ordinarily perform on behalf of a Covered Person. No Payment to legally responsible individuals shall be made unless under extraordinary circumstances and approved by the State.

(a) Legally Responsible Individual: Any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care for the child, or; (b) a spouse.

SECTION 5
HEALTH PLAN AND SUBCONTRACTOR REQUIREMENTS

5.1 **Prompt Payment.** Subcontractor or Health Plan (as applicable) 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 or Health Plan (as applicable) otherwise requests assistance from Provider, Subcontractor or Health Plan will be responsible for third party collections in accordance with the terms of the State Contract. Subcontractor or Health Plan shall not be responsible for any payments owed to Provider for services that were rendered prior to a Covered Person's enrollment, even if such services fell within any applicable period of retroactive eligibility for Medicaid. Subcontractor or Health Plan shall not be financially liable for services rendered to treat a non-emergent condition in a hospital emergency room (except to assess whether a condition warrants treatment as Emergency Services, or as required elsewhere in law), unless the services were prior authorized or otherwise conformed to the terms of the Agreement. Subcontractor or Health Plan shall not be liable to pay claims to Provider if the validity of the claim is being challenged by Subcontractor or Health Plan through a grievance or appeal, unless Subcontractor or Health Plan is obligated to pay the claim or a portion of the claim through the Agreement.

5.2 **No Incentives to Limit Medically Necessary Services.** Neither Health Plan nor 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.

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

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

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

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

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

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

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

5.5 **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, and refuse to renew or terminate Provider in accordance with the terms of the State Contract and applicable law and regulation.

SECTION 6
OTHER REQUIREMENTS

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

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

6.3 **Independent Contractor Relationship.** It is expressly agreed that Subcontractor and Provider shall act in an independent capacity and not as an agent, officer, employee, partner, or associate of each other or of the State. Provider staff will not hold themselves out as, nor claim to be, officers or employees of Subcontractor or Health Plan or the State by reason hereto. It is further expressly agreed that neither the Agreement nor this Appendix shall be construed as a partnership or joint venture between Subcontractor, Health Plan, Provider, and the State.