CALIFORNIA MEDICAID PROGRAM

REGULATORY REQUIREMENTS APPENDIX

DOWNSTREAM PROVIDER

THIS CALIFORNIA DOWNSTREAM PROVIDER 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

The requirements of this Appendix apply 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, including the State Contracts and related programs (collectively the "State Program") as governed by the California Department of Health Care Services. 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 laws 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 Health Plan or Subcontractor are required to amend or supplement this Appendix as required or requested by the State to comply with federal or State regulations, Health Plan and/or Subcontractor will unilaterally initiate such additions, deletions or modifications and such changes shall be effective as set forth in a notice from Health Plan or Subcontractor to Provider.

SECTION 2
DEFINITIONS

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

2.1 Covered Person: An individual who is currently enrolled with Health Plan for the provision of services under the State Program. A newborn of a Covered Person is covered under the mother's membership for the month of birth and the following calendar month. A newborn born in the month immediately preceding the mother's enrollment as a Covered Person is covered under the mother's membership during the mother's first month of enrollment. A Covered Person may also be referred to as an Enrollee, Member or Customer under the Agreement.

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

2.3 Department or DHCS: California Department of Health Care Services.

2.4 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 Community Plan of California.

2.5 Provider: An appropriately licensed and/or certified hospital, ancillary provider, physician group, individual physician or other health care provider who has entered into an Agreement.

2.6 State: The State of California or its designated regulatory agencies.

2.7 State Contract: Health Plan's contract(s) with the Department for the purpose of providing and paying for Covered Services to Covered Persons enrolled in the State Program.

2.8 State Program: The Medi-Cal Managed Care Program operated in California by the Department. 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 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:

(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: Health care services required for alleviation of severe pain or immediate diagnosis and treatment of unforeseen medical conditions which if not immediately diagnosed or treated would lead to death or disability. Such emergency is deemed to continue until: (a) In reasonable medical judgment, Covered Person's condition has stabilized sufficiently as to permit either: (i) discharge, or; (ii) referral or transfer of the Covered Person, in accordance with instructions from Covered Person's plan to such level of treatment or case as may be appropriate, and; (b) A reasonable time within which to complete such discharge, referral or transfer.

(c) Medically Necessary or Medical Necessity: Services provided in accordance with 42 CFR 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:

(i) Necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain;
(ii) 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;
(iii) Consistent with the generally accepted medical standards as determined by the State Program, and not experimental or investigational;
(iv) 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
(v) Furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the Provider.

In addition to the services set forth above, "Medically Necessary" shall specifically include those standards set forth in 22 CCR 51340 and 51340.1.

"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. 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.

Emergency health care services shall be made available and accessible by Provider twenty-four hours a day, seven days a week.

3.5 Domestic Partner Visits. Provider and its Represented Providers agree to permit a Covered Person to be visited by a Covered Person's domestic partner, the children of the Covered Person's domestic partner, and the domestic partner of the Covered Person's parent or child.

3.6 Hold Harmless. Provider shall look solely to Health Plan and/or Subcontractor 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 and/or Subcontractor cannot or will not pay for such Covered Services. In accordance with 42 CFR 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 and/or Subcontractor 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 Contractor applicable law. Neither the State, the Department nor Covered Persons shall be in any manner liable for the debts and obligations of Health Plan and/or Subcontractor and under no circumstances shall Health Plan, Subcontractor, or any providers used to deliver services covered under the terms of the State Contract, charge Covered Persons for Covered Services.

Except for applicable co-payments and deductibles, Provider will not invoice or balance bill any Covered Persons for the difference between Provider's billed charges and the reimbursement paid by Health Plan and/or Subcontractor for any Covered Service.

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

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

3.8 Non-Physician Medical Practitioners. If Provider provides Covered Services through nurse practitioners, physician assistants, or nurse midwives ("Non-Physician Medical Practitioners"), the ratio of one physician to Non-Physician Medical Practitioners may not exceed the following: (i) four (4) nurse practitioners; (ii) three (3) nurse midwives; (iii) four (4) physician assistants; or (iv) four (4) of the above individuals in any combination which does not exceed three (3) nurse midwives or two (2) physician assistants. Each individual Non-Physician Medical Practitioner shall maintain a full-time equivalent provider to patient caseload of no more than one thousand (1,000).

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 Assignment and Delegation. Provider and its Represented Providers agree that the assignment or delegation of any part of this Agreement shall be void unless prior written approval is obtained from the Department in those instances where prior approval is required. In the event any part of this Agreement is assigned or delegated, such assignment or delegation must include all of the requirements of this Appendix, and applicable requirements of the State Contract. Provider agrees to make available to Health Plan, Subcontractor and the Department, upon request, copies of any and all assignments, delegations, subcontracts, or similar instruments (collectively "Subcontracts"). With respect to any Subcontract, unless prior written approval is obtained from the Department in those instances where prior approval by the Department is required, such Subcontracts will be considered void. Provider shall notify the Department in the event a Subcontract is amended or terminated.

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. Such records shall be maintained for a period of not less than five (5) years from the close of the fiscal year in which Agreement was in effect, or such other period as required by law. If records are under review or audit, they must be retained until resolution of such action. 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 Health Plan and/or Subcontractor 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 Site Access. Provider acknowledges and agrees that Health Plan and Subcontractor shall have access to conduct site reviews of all Provider service sites in accordance with Medi-Cal Managed Care Division Policy Letter 02-02.

3.14 Examination Sites. Provider acknowledges and agrees that if any performance under this Agreement or any Subcontract includes any tests or examination of materials derived from the human body for the purpose of providing information, diagnosis, prevention, treatment or assessment of disease, impairment, or health of a human being, all locations at which such examinations are performed shall meet the requirements of 42 USC Section 263a (CLIA) and the regulations thereto.

3.15 Government Audit; Investigations. Provider acknowledges and agrees that the State, DHCS, DMHC, CMS, the Office of Inspector General, the Comptroller General, Department of Justice, 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 books, encounter data, 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 or at such other mutually agreed upon location in California. 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. If DHCS, CMS or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, an audit the Provider at any time. Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the Provider from participation in the Medi-Cal program; seek recovery of payments made to the Provider, impose other sanctions provided under the state plan, and direct Subcontractor and/or Health Plan to terminate Provider due to fraud.

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

3.17 Contraceptive Methods and Informed Consent. Provider shall ensure that Covered Persons are informed of the full array of covered contraceptive methods when appropriate and that informed consent is obtained from Covered Persons for sterilization consistent with requirements of applicable law.

3.18 Minor Consent Services Program. Provider and its Represented Providers will comply with the Medi-Cal Minor Consent Services program. Minors do not need parental consent in order to access services related to sexual assault, including rape, drug or alcohol abuse (for children 12 years of age or older), pregnancy, family planning, and STDs and HIV/AIDS (in children 12 years of age or older).

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

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

(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 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.

3.20 Solicitations or Advancement for Employees. Provider will, in all solicitations or advancements for employees placed by or on behalf of Provider, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era.

3.21 Notice to Labor Unions. Provider will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the Federal Government or the State, advising the labor union or workers' representative of the Provider's commitments under the relevant provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

3.22 Physician Incentive Plans. In the event Provider participates in a physician incentive plan

("PIP") under the Agreement, Provider agrees that such PIPs must comply with 42 CFR 417.479, 42 CFR 438.6(h), 42 CFR 422.208, and 42 CFR 422.210, as may be amended from time to time. Neither Health Plan, 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.

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

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

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

3.24 Excluded Individuals and Entities. Provider certifies to the best of Provider's knowledge and belief that neither it nor any of its principals or owners, 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 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 the Agreement. Provider shall immediately report to Health Plan and 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. Federal and State exclusion databases must be reviewed monthly to ensure that no employee or contractor has been excluded. Health Plan and Subcontractor will terminate the Agreement immediately and exclude from its network any provider who has been excluded or has been terminated from the Medicare, Medicaid or CHIP program in any state.

3.25 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 thirty-five (35) calendar days of a request for such information in accordance with 42 CFR 455.105. Additionally, Provider must cooperate with the Department for submission of fingerprints upon a request from the Department or CMS in accordance with 42 CFR 455.434.

3.26 Cultural Competency and Access. Provider shall participate in Health Plan's, 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, and 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 at all provider sites. 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. Subcontractor and/or Health Plan will provide cultural competency, sensitivity, and diversity training. Provider shall comply with language assistance standards developed pursuant to Health & Safety Code Sec.1367.04.

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

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

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

In accordance with Health Plan's policies and the Deficit Reduction Act of 2005 (DRA), Provider shall have written policies for its employees, contractors or agents that: (a) provide detailed information about the federal False Claims Act (established under sections 3729 through 3733 of title 31, United States Code), including, if any entity makes or receives annual payments under the State Program of at least $5,000,000, such entity must establish certain minimum written policies and information communicated through an employee handbook relating to the Federal False Claims Act in accordance with 42 CFR §438.600; (b) cite administrative remedies for false claims and statements (established under chapter 38 of title 31, United States Code) and whistleblower protections under federal and state laws; (c) reference state laws pertaining to civil or criminal penalties for false claims and statements; and (d) with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in federal health care programs (as defined in section 1128B(f)), include as part of such written policies, detailed provisions regarding Provider's policies and procedures for detecting and preventing fraud, waste, and abuse. Provider agrees to train its staff on the aforesaid policies and procedures.

3.29 Tort and Workers Compensation Claims. Provider shall not make any claim for recovery of the value of Covered Services rendered to Covered Persons when such recovery would result from an action involving the tort or Workers Compensation liability of a third party, casualty liability coverage, or any other third-party liability which could result in recovery by the Covered Person of funds for which the Department has lien rights under Welfare and Institutions Code Section 14124.70. Provider shall identify and notify Plan of cases in which such an action could result in recovery by the Covered Person. Provider shall notify Plan immediately upon the discovery of such cases and shall provide any requested information promptly to Plan. The Department retains the right to such third-party tort and Workers Compensation liability, and casualty liability recoveries with respect to Covered Persons as set forth in Welfare and Institutions Code Section 14124.70 et seq.

3.30 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.

3.31 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, as well as applicable requirements of the DHCS, Medi-Cal Managed Care Program. Provider understands that payment of a claim by Health Plan, Subcontractor, 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 Health Plan 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 Health Plan or Subcontractor provides notice that a credible allegation of fraud exists and there is a pending investigation.

3.32 Continuity of Care. Provider shall cooperate with Health Plan and Subcontractor and provide Covered Persons with continuity of treatment, including coordination and transfer of care to the extent required under law and State Contract and according to the terms of the Agreement, in the event Provider's participation with Health Plan and/or Subcontractor terminates for any reason during the course of a Covered Person's treatment by Provider. Additionally, Provider will assist in the orderly transfer of necessary data and records to Health Plan, Subcontractor, a successor to Health Plan or Subcontractor, or the Department. Provider will assist in the transition of Covered Persons, and in ensuring, to the extent possible, continuity of Covered Person-Provider relationships. In doing this, the Provider will make available to Health Plan or the Department copies of medical records, patient files, and any other pertinent information, including information maintained by any subcontractor, necessary for efficient case management of Covered Persons, as determined by the Director of the Department. In no circumstances will a Covered Person be billed for this activity.

3.33 Emergency Services Related Drugs. When Provider provides Emergency Services to a Covered Person and such Covered Person's treatment requires the use of drugs, Provider shall provide to the Covered Person at least a 72-hour supply of Medically Necessary drugs, which may include an initial dose and a prescription for additional drugs.

3.34 Advance Directives. 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 49, subpart I, and 42 CFR 417.436(d).

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

is amended or terminated. Notice to the Department is considered given when properly addressed and deposited in the United States Postal Service as first-class registered mail, postage attached. Notice should be mailed to the Department of Health Care Services, Medi-Cal Managed Care Division, County Organized Health Systems MS 4408, P.O. Box 997413, Sacramento, CA 95899.

3.36 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 Health Plan and Subcontractor any provider preventable conditions in accordance with 42 CFR 438, including but not limited to 438.6(f)(2)(i).

3.37 Surcharge. Provider agrees that no surcharge shall be paid for Covered Services. In the event a notice of surcharge is received, Health Plan shall take appropriate action against such surcharge.

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 Encounter Data. 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.

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

3.41 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.

3.42 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.

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

3.44 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.

3.45 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.

3.46 Records Related to Recovery for Litigation. In accordance with State Contract, Exhibit E, Attachment 2, Provision 24, Provider agrees to timely gather, preserve and provide to DHCS, in the form and manner specified by DHCS, any information specified by DHCS, subject to any lawful privileges, in Provider's possession, relating to threatened or pending litigation by or against DHCS.

3.47 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 or Health Plan's quality improvement and utilization review and management activities. This shall include, but not be limited to, participation in any internal and external quality assurance, utilization review, peer review, and grievance procedures established by Subcontractor and/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.

3.48 Coordination of Care. To the extent Provider is responsible for the coordination of care for Covered Persons, Subcontractor and/or Health Plan agree to share with Provider any utilization data that DHCS has provided to Subcontractor and/or Health Plan, and Provider agrees to receive the utilization data and use it as Provider is able for the purpose of Covered Person care coordination.

SECTION 4
SUBCONTRACTOR AND HEALTH PLAN REQUIREMENTS

4.1 Prompt Payment. Health Plan and/or 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 clean claims shall be determined in accordance with federal and/or State third party liability law and the terms of the State Contract. Unless Health Plan and/or Subcontractor otherwise requests assistance from Provider, Health Plan and/or Subcontractor will be responsible for third party collections in accordance with the terms of the State Contract.

Health Plan and/or Subcontractor shall pay claims as soon as practical, but no later than 45 working days, unless the claim or portion thereof is contested by Health Plan and/or Subcontractor. In the event Health Plan and/or Subcontractor contests a claim, Health Plan and/or Subcontractor will notify the claimant in writing that the claim is contested or denied within 45 working days. The requirements of this paragraph apply to Health Plan and Subcontractor, as well as any claims processing organization, plan or capitated provider that processes or pays claims on behalf of Health Plan and Subcontractor.

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

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

4.4 Communications with Covered Persons. Health Plan and 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:

(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/or 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 its termination rights under the Agreement, Health Plan and/or Subcontractor shall have the right to revoke any functions or activities Health Plan and/or Subcontractor delegates to Provider under the Agreement or impose other sanctions consistent with the State Contract if in Health Plan and/or Subcontractor's reasonable judgment Provider's performance under the Agreement is inadequate. Health Plan and/or 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.

4.6 Payment. Upon termination of the Agreement, Health Plan and/or Subcontractor shall be liable for Covered Services rendered by Provider, other than for co-payments as defined in the California Health and Safety Code Section 1345(g), to a Covered Person who retains eligibility under the Agreement or by operation of law under the care of such Provider at the time of such termination until the services being rendered to the Covered Person by Provider are completed, unless Health Plan and/or Subcontractor makes reasonable and medically appropriate provision for the assumption of such services by contacting Provider.

4.7 Submission of a Provider Dispute. Health Plan and/or Subcontractor shall provide a fast, fair and cost-effective dispute resolution mechanism under which Provider may submit disputes to Health Plan and/or Subcontractor. Provider may obtain specific information regarding Health Plan's and/or Subcontractor's provider dispute resolution mechanism in Health Plan's and/or Subcontractor's administrative manual. Provider may submit information regarding provider disputes to Health Plan and/or Subcontractor by calling (800) 542-8789 or by writing to Provider Dispute Resolution HMO, P.O. Box 30764, Salt Lake City, UT 84130-0764. Health Plan and/or Subcontractor will inform Provider of any changes to the provider dispute procedures, including any changes to the procedures for processing and resolving disputes and the location and telephone number where information regarding disputes may be submitted.

4.8 Emergency Service Providers. To the extent required by the State Contract, Exhibit A, Attachment 8, Provision 31, Health Plan and/or Subcontractor is responsible for coverage and payment of emergency services and must cover and pay for emergency services regardless of whether the provider that furnishes the services has an agreement with Health Plan and/or Subcontractor.

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, , applicable provider manuals, and protocols, policies and procedures that Health Plan and/or 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 and/or 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. Health Plan and/or Subcontractor agrees to inform Provider of prospective requirements added by DHCS to the State Contract before the requirement would be effective, and Provider agrees to comply with the new requirements within 30 days of the effective date, unless otherwise instructed by DHCS and to the extent possible. As required in the State Contract, Provider is entitled to all protections afforded it under the Health Care Providers' Bill of Rights.

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 or requests by DHCS. 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, Subcontractor and/or Health Plan 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 Claims Submission. Parties agree that Provider must submit its claims for reimbursement (whether by claim form, invoice or other method, as set forth in this agreement) within 180 days of the date of service. If the claim is not submitted by Provider within this timeframe, Provider will not be reimbursed for the services, and Provider may not charge Covered Person.

5.4 State Review and Approval. The Agreement and this Appendix, and any applicable Amendment or revision to the Agreement or this Appendix, are subject to approval of Department in accordance with applicable State law and State Contract provisions.

5.5 Amendments and Material Changes. Parties agree to comply with California Health and Safety Code Section 1375.7(b)(1)(A) when amending or making material changes to the Agreement, as applicable. This includes, but is not limited to, authority for Health Plan and/or Subcontractor to change a material term of the contract, unless the change has first been negotiated and agreed to by Provider and Health Plan and/or Subcontractor or the change is necessary to

comply with State or federal law or regulations or any accreditation requirements of a private sector accreditation organization. If a change is made by amending a manual, policy, or procedure document referenced in the Agreement, Health Plan and/or Subcontractor shall provide 45 business days' notice to Provider, and Provider has the right to negotiate and agree to the change. If Health Plan and/or Subcontractor and Provider cannot agree to the change to a manual, policy, or procedure document, Provider has the right to terminate the Agreement prior to the implementation of the change. In any event, Health Plan and/or Subcontractor shall provide at least 45 business days' notice of its intent to change a material term, unless a change in State or federal law or regulations or any accreditation requirements of a private sector accreditation organization requires a shorter timeframe for compliance. However, if the parties mutually agree, the 45-business day notice requirement may be waived. Nothing in this provision limits the ability of the parties to mutually agree to the proposed change at any time after Provider has received notice of the proposed change