NORTH CAROLINA STATE PROGRAM
REGULATORY REQUIREMENTS APPENDIX
PROVIDER

THIS NORTH CAROLINA STATE PROGRAM REGULATORY REQUIREMENTS APPENDIX (this "Appendix") supplements and is made part of the provider agreement (the "Agreement") between UnitedHealthcare of North Carolina, Inc. and the party named in the Agreement ("Provider").

SECTION 1
APPLICABILITY

The requirements of this Appendix apply to benefit plans sponsored, issued or administered by UnitedHealthcare of North Carolina, Inc. (referred to in this Appendix as "United") under the State's Medicaid program, CHIP program and, as applicable, benefit plans for other state-based healthcare programs for low-income individuals (the "State Program") as governed by the State's designated regulatory agencies. In the event of a conflict between this Appendix and other appendices or any provision of the Agreement, the provisions of this Appendix shall control except with regard to benefit plans outside the scope of this Appendix or unless otherwise required by law. In the event United is required to amend or supplement this Appendix as required or requested by the State to comply with federal or State regulations, United will unilaterally initiate such additions, deletions or modifications.

The effective date of any Provider added under this Agreement shall be the later of the effective date of this Agreement or the date by which the Provider's enrollment as a Medicaid enrolled provider is effective within NC Tracks or successor NC Medicaid provider enrollment system(s).

SECTION 2
DEFINITIONS

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

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

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

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

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

2.5 **Department:** The State of North Carolina's Department of Health and Human Services.

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

2.7 **State:** The State of North Carolina or its designated regulatory agencies.

2.8 **State Contract:** A contract between United and Department for the purpose of providing and paying for Covered Services to Covered Persons enrolled in the State Program.

2.9 **State Program:** The Medicaid program, CHIP program and, as applicable, benefit plans for other state-based healthcare programs for low-income individuals, 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 United and Provider agree to undertake, which include the following:

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

i) Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) 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.

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

iii) Medically Necessary or Medical Necessity: Medical necessity is determined by generally accepted North Carolina community practice standards as verified by independent Medicaid consultants. As required by 10A NCAC 25A.0201, a medically necessary service may not be experimental in nature.

3.2 **Medicaid or CHIP Participation.** Provider must be enrolled with the State as a Medicaid or CHIP provider, as applicable to participate in United's Medicaid or CHIP network. Upon notification from the State that Provider's enrollment has been denied or terminated, United must terminate Provider immediately and will notify affected Covered Persons that Provider is no longer participating in the network. United will exclude from its network any provider who 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 **Hold Member Harmless.** Provider agrees to hold the Covered Person harmless for charges for any covered service. Provider agrees not to bill a Covered Person for medically necessary services covered by United so long as the Member is eligible for coverage.

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 United 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 United and under no circumstances shall United, or any providers used to deliver services covered under the terms of the State Contract, charge Covered Persons for Covered Services.

If the medical assistance services are not Covered Services, prior to providing the service, Provider shall inform the Covered Person of the non-covered service and have the Covered Person acknowledge the information. If the Covered Person still requests the service, Provider shall obtain such acknowledgement in writing prior to rendering the service. If United determines a Covered Person was charged for Covered Services inappropriately, such payment may be recovered, as applicable.

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

3.6 **Indemnification.** To the extent applicable to Provider in performance of the Agreement, Provider shall indemnify, defend and hold the Department and its employees harmless from and against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses, including court costs and attorney fees, to the extent proximately caused by any negligent act or other intentional misconduct or omission of Provider, its agents, officers, employees or contractors arising from the Agreement. The Department may waive this requirement for public entities if Provider is a state agency or sub-unit as defined by the State or a public health entity with statutory immunity. This clause shall survive the termination of the Agreement for any reason, including breach due to insolvency.

3.7 **Provider Selection.** To the extent applicable to Provider in performance of the Agreement, Provider shall comply with 42 CFR 438.214, as may be amended from time to time, which includes, but is not limited to the selection and retention of providers, credentialing and recredentialing requirements and nondiscrimination. Provider will cooperate and complete the credentialing and recredential processes implemented by the Department. Provider will complete reenrollment and recredentialing before contract renewal in the appropriate time period. Further, as required by 45 CFR 455.410, Provider must be an enrolled Medicaid provider. Failure to be an enrolled Medicaid basis for termination of the Agreement.

3.8 **Restrictions on Referrals.** Provider shall not make inappropriate referrals for designated health services to health care entities with which Provider or a member of Provider's family has a financial relationship, pursuant to federal anti-kickback and physician self- referral laws that prohibit such referrals.

3.9 **Subcontracts.** Provider's duties and obligations under the Agreement shall not be assigned, delegated, or transferred without the prior written consent of United. If Provider subcontracts or delegates any functions of the Agreement, the subcontract or delegation must be in writing and include all of the requirements of this Appendix, applicable requirements of the State Contract, and applicable laws and regulations. Provider further agrees to promptly amend its agreements with such subcontractors, in the manner requested by United, to meet any additional State Program requirements that may apply to the services.

3.10 **Records Retention.** As required under State or federal law or the State Contract, Provider shall maintain an adequate record keeping system for recording services, charges, dates and all other commonly accepted information elements for services rendered to Covered Persons. All financial records shall follow generally accepted accounting principles. Medical records and supporting management systems shall include all pertinent information related to the medical management of each Covered Person. Other records shall be maintained as necessary to clearly reflect all actions taken by Provider related to services provided under the State Contract. 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 United if the Agreement is continuous.

The financial auditors of the Department shall also have full access to all financial records and other information determined by the Department to be necessary for the Department's substantiation of the monthly payment(s). These audit rights are in addition to any audit rights any federal agency may have regarding the use of federally allocated funds.

3.11 **Access to Provider Records.** Provider agrees to provide at no cost to the following entities or their designees with prompt, reasonable, and adequate access to Agreement and any records, books, documents, and papers that relate to Agreement and/or the Provider's performance of its responsibilities under the Agreement for purposes of examination, audit, investigation, contract administration, the making of copies, excerpts or transcripts, or any other purpose Department deems necessary for contract enforcement or to perform its regulatory functions:

i) The United States Department of Health and Human Services or its designee;

ii) The Comptroller General of the United States or its designee;

iii) Department, its Medicaid managed care program personnel, or its designee;

iv) The Office of Inspector General;

v) North Carolina Department of Justice Medicaid Investigations Division;

vi) Any independent verification and validation contractor, audit firm, or quality assurance contractor acting on behalf of Department;

vii) The North Carolina Office of State Auditor, or its designee;

viii) A state or federal law enforcement agency;

ix) And any other state or federal entity identified by Department, or any other entity engaged by Department.

Provider shall cooperate with all announced and unannounced site visits, audits, investigations, post-payment reviews, or other program integrity activities conducted by the Department.

Nothing in this Provision shall be construed to limit the ability of the federal government, the Centers for Medicare and Medicaid Services, the U.S. Department of Health and Human Services Office of Inspector General, the U.S. Department of Justice, or any of the foregoing entities' contractors or agents, to enforce federal requirements for the submission of documentation in response to an audit or investigation. Provider shall make copies of medical records available to United and the Department in conjunction with its regulation of United. The records shall be made available and furnished immediately upon request in either paper or electronic form, at no cost to the requesting party.

3.12 **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.

3.13 **Privacy; Confidentiality.** Provider understands that the use and disclosure of information concerning Covered Persons is restricted to purposes directly connected with the administration of the State Program and shall maintain the confidentiality of Covered Person's information and records as required by the State Contract and in federal and State law including, but not limited to, all applicable privacy, security and Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Public Law 104-191, and associated implementing regulations, including but not limited to 45 CFR Parts 160, 162, 164, as applicable and as may be amended from time to time, and shall safeguard information about Covered Persons in accordance with applicable federal and State privacy laws and rules including but not limited to 42 CFR §438.224, 42 CFR Part 2, and 42 CFR Part 431, Subpart F; 42 CFR Part 434 and 42 CFR 438.3 (if applicable), as may be amended from time to time.

Access to member identifying information shall be limited by Provider to persons or agencies that require the information in order to perform their duties in accordance with this Agreement, including the U.S. Department of Health and Human Services (HHS), the Department and other individuals or entities as may be required. (See 42 CFR §431.300, et seq. and 45 CFR Parts 160 and 164.) Any other party shall be granted access to confidential information only after complying with the requirements of state and federal laws, including but not limited to HIPAA, and regulations

pertaining to such access. Provider is responsible for knowing and understanding the confidentiality laws listed above as well as any other applicable laws. Nothing herein shall prohibit the disclosure of information in summary, statistical or other form that does not identify particular individuals, provided that de-identification of protected health information is performed in compliance with the HIPAA Privacy Rule.

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

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

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

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

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

3.15 Compliance with State and Federal Laws. Provider understands and agrees that it is subject to all state and federal laws, rules, regulations, waivers, policies and guidelines, and court-ordered consent decrees, settlement agreements, or other court orders that apply to the Agreement and United's managed care contract with the Department, and all persons or entities receiving state and federal funds. Provider understands and agrees that any violation by a provider of a state or federal law relating to the delivery of services pursuant to the Agreement, or any violation of United's contract with Department could result in liability for money damages, and/or civil or criminal penalties and sanctions under state and/or federal law.

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

3.16 Physician Incentive Plans. In the event Provider participates in a physician incentive plan ("PIP") under the Agreement, Provider agrees that such PIPs must comply with 42 CFR 417.479, 42 CFR 438.3, 42 CFR 422.208, and 42 CFR 422.210, as may be amended from time to time. Neither United nor Provider may make a specific payment directly or indirectly under a PIP to a physician or physician group as an inducement to reduce or limit Medically Necessary services furnished to an individual Covered Person. PIPs must not contain provisions that provide incentives, monetary or otherwise, for the withholding of services that meet the definition of Medical Necessity.

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

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

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

3.18 Excluded Individuals and Entities. By signing the Agreement, Provider certifies to the best of Provider's knowledge and belief that neither it nor any of its employees, principals, nor any providers,

subcontractors or consultants or persons with an ownership or controlling interest in the Provider (an owner including the Provider himself or herself), or an agent or managing employee of the Provider, with whom Provider contracts and who are providing items or services that are significant and material to Provider's obligations under the Agreement is:

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

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

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

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

Provider shall provide physical access, reasonable accommodations, and accessible equipment for Covered Persons with physical or mental disabilities. In addition, Provider must provide the following interpreting and translation services:

i) Provider must provide qualified sign language interpreters if closed captioning is not the appropriate auxiliary aid for Covered Person;

ii) Provider must ensure Provider's staff are trained to appropriately communicate with Covered Persons with various types of hearing loss;

iii) Provider shall report to United, in a format and frequency to be determined by United, whether hearing loss accommodations are needed and provided and the type of accommodation provided.

3.20 **Marketing.** As required under State or federal law or the applicable State Contract, any marketing materials developed and distributed by Provider as related to the performance of the Agreement must be submitted to United to submit to the State Program for prior approval.

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

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

United may immediately terminate the Agreement upon a confirmed finding of fraud, waste or abuse by the Department or the North Carolina Department of Justice Medicaid Investigations Division.

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

3.24 **Encounter Data.** Provider agrees to cooperate with United to comply with United's obligation to prepare timely encounter data submissions, reports, and clinical information including, without limitation, child and adolescent health check-up reporting, EPSDT encounters, and cancer screening

encounters, as applicable, and such other reporting regarding Covered Services as may be required under the State Contract. Encounter data must be accurate and include all services furnished to a Covered Person, including capitated provider's data and rendering provider information. Encounter data must be provided within the timeframes specified and in a form that meets United and State requirements. By submitting encounter data to United, Provider represents to United that the data is accurate, complete and truthful, and upon United's request Provider shall certify in writing, that the data is accurate, complete, and truthful, based on Provider's best knowledge, information and belief. Provider shall not submit claim or encounter data for Covered Services directly to the Department.

3.25 **Claims Information.** Provider shall promptly submit to United the information needed to make payment and shall identify third party liability coverage, including Medicare and other insurance, and if applicable seek such third-party liability payment before submitting claims to United. United shall accept delivery of any requested clinical documentation needed to process claims through a mutually agreed to solution via electronic means available to Provider and shall not require that the information be transmitted via facsimile. Provider understands and agrees that each claim Provider submits to United constitutes a certification that the claim is true and accurate to the best of Provider's knowledge and belief and that the Covered Services are 1) Medically Necessary and 2) have been provided to the Covered Person prior to submitting the claim. Provider agrees to have policies and procedures that recognize and accept Medicaid as the payer of last resort. Providers agrees not to bill Covered persons for Covered Services any amount greater than would be owed if the provider or referral provider provided the service directly as provided in 42 C.F.R. §§ 438.3(k) and 438.230(c)(1)-(2). Pursuant to the State Contract, Provider shall not submit claim or encounter data for Covered Services directly to the Department.

3.26 **Insurance Requirements.** As applicable, Provider shall secure and maintain during the term of the Agreement insurance, including professional liability insurance, appropriate to the services to be performed under the Agreement. Provider must notify United of subsequent changes in status of insurance, including professional liability insurance,

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

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

submitted for payment for laboratory services.

3.29 **Quality; Utilization Management.** Pursuant to any applicable provider manuals and related protocols, or as elsewhere specified under the Agreement, Provider agrees to cooperate with United's quality improvement and management programs, utilization review and management programs, and provider sanctions programs. This shall include, but not be limited to, participation in any internal and external quality assurance, utilization review, peer review, and grievance procedures established by United or as required under the State Contract to ensure that Covered Persons have due process for their complaints, grievances, appeals, fair hearings or requests for external review of adverse decisions made by United or Provider. Provider shall adhere to the quality assurance and utilization review standards of the State Program and shall monitor quality and initiate corrective action to improve quality consistent with the generally accepted level of care. None of the above references programs or activities shall override the professional or ethical responsibility of the Provider or interfere with the Provider's ability to provide information or assistance to their patients.

3.30 **Non-Discrimination and Equitable Treatment of Covered Persons**. Provider agrees to render Provider Services to Covered Persons with the same degree of care and skills as customarily provided to the Provider's patients who are not Covered Persons, according to generally accepted standards of medical practice. Provider and United agree that Covered Persons and non-Covered Persons should be treated equitably. Provider agrees not to discriminate against Covered Persons on the basis of race, color, national origin, age, sex, gender, or disability.

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

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

3.33 **Continuity of Care.** Provider shall cooperate with United and provide Covered Persons with continuity of treatment, including coordination of care to the extent required under law and State Contract and according to the terms of the Agreement, in the event Provider's participation with United terminates during the course of a Covered Person's treatment by Provider, except in the case of adverse reasons on the part of Provider. In the event of insolvency by United, Provider must comply with the State Contract's transition of administrative duties and records and continuity of care requirements, including when inpatient care is ongoing. If United provider or arranges for the delivery of health care services on a prepaid basis, inpatient care shall be continued until the patient is ready for discharge.

Parties agree to comply with State Contract Section V.C.4.d and with N.C. G.S 58-67- 88(d), (e), (f), and (g), as applicable. In instances in which Provider leaves United's network for expiration or nonrenewal of the Agreement and the Covered Person is in ongoing course of treatment, as defined and required in the State Contract, or has an ongoing special condition, United shall permit the Covered Person to continue seeing Provider, regardless of the Provider's network status, in accordance with N.C. Gen. Stat. § 58-67-88(d), (e), (f), and (g).

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

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

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

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

3.38 **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 United any provider preventable conditions in accordance with 42 CFR §§ 434.6(a)(12), 438, including but not limited to § 438.3(g), and § 447.26.

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

United's resolution of overpayments and underpayments shall be administered in accordance with NCGS § 58-3-225(h), except that not less than sixty (60) Calendar Days before United seeks to recover any overpayments or offsets any future payments from Provider, United shall provide the written notice required under NCGS § 58-3-225(h).

3.40 **Covered Person Appeals and Grievances.** Provider agrees to cooperate with Covered Person in regard to Covered Person's appeals and grievance procedures.

3.41 **Liability.** Provider understands and agrees that the Department does not assume liability for the actions of, or judgments rendered against, United, its employees, agents or subcontractors. Further, Provider understands and agrees that there is no right of subrogation, contribution, or indemnification against Department for any duty owed to the Provider by United or any judgment rendered against United.

3.42 **Department Authority Related to the Medicaid Program.** Provider agrees and understands that in the State of North Carolina, the Department is the single state Medicaid agency designated under 42 C.F.R. § 431.10 to administer or supervise the administration of the state plan for medical assistance. The Division of Health Benefits is designated with administration, provision, and payment for medical assistance under the Federal Medicaid (Title XIX) and the State Children's Health Insurance (Title XXI) (CHIP) programs. The Division of Social Services (DSS) is designated with the administration and determination of eligibility for the two programs.

3.43 **High Level Clinical Setting.** Pursuant to the State Contract, as applicable, Provider shall notify United when a Covered Person in a high-level clinical setting is being discharged.

High level clinical settings include, but are not limited to:

(i) Hospital/Inpatient acute care and long-term acute care;

(ii) Nursing Facility;

(iii) Adult Care Home;

(iv) Inpatient behavioral health services;

(v) Facility-based crisis services for children;

(vi) Facility-based crisis services for adults: and

(vii) ADATC.

SECTION 4
ADDITIONAL PROVIDER REQUIREMENTS FOR SPECIFIC ACTIVITIES

4.1 Perinatal Care Providers. Providers who provide perinatal care services to Covered Persons agree to comply with the Department's Pregnancy Management Program. The requirements include, but are not limited to:

i) Complete the standardized risk-screening tool at each initial visit;

ii) Allow United's designated vendor access to medical records for auditing purposes to measure performance on specific quality indicators;

iii) Commit to maintaining or lowering the rate of elective deliveries prior to 39 weeks gestation;

iv) Commit to decreasing the cesarean section rate among nulliparous women;

v) Offer and provide 17 alpha-hydroxyprogesterone caproate (17p) for the prevention of preterm birth to women with a history of spontaneous preterm birth who are currently pregnant with a singleton gestation;

vi) Complete a high-risk screening on each pregnant Medicaid Managed Care Member in the program and integrate the plan of care with local pregnancy care management;

vii) Decrease the primary cesarean delivery rate if the rate is over the Department's designated cesarean rate; {Note: the Department will set the rate annually, which will be at or below twenty percent (20%); and

viii) Ensure comprehensive post-partum visits occur within fifty-six (56) days of delivery.

Providers further agree to send all screening information and applicable medical record information for Covered Persons in the Care Management of High-Risk Pregnancies to United and the LHDs or other applicable local care management entities that are contracted for the provision of providing care management services for high risk pregnancy within one business day of the Provider completing the screening.

42 **Advanced Medical Home Providers.** Providers who are an Advanced Medical Home (AMH) as defined by the State Contract agree to comply with the Department's Advanced Medical Home Program. The requirements include, but are not limited to:

i) Accept Covered Persons and be listed as a primary care provider in United's Covered Person-facing materials for the purpose of providing care to Covered Persons and managing their health care needs;

ii) Provide primary care and patient care coordination services to each Covered Person, in accordance with United's policies;

iii) Provide or arrange for primary care coverage for services, consultation or referral, and treatment for emergency medical conditions, 24 hours per day, 7 days per week. Automatic referral to the hospital emergency department for services does not satisfy this requirement;

iv) Provide direct patient care a minimum of 30 office hours per week;

v) Provide preventive services, in accordance with *Section VII. Attachment M. Table 1: Required Preventive Services* of the State Contract;

vi) Maintain a unified patient medical record for each Covered Person following United's medical record documentation guidelines;

vii) Promptly arrange referrals for medically necessary health care services that are not provided directly and document referrals for specialty care in the medical record;

viii) Transfer the Covered Person's medical record to the receiving provider upon the change of primary care provider at the request of the new primary care provider or United (if applicable) and as authorized by the Covered Person within 30 days of the date of the request, free of charge;

ix) Authorize care for Covered Person or provide care for the Covered Person based on the standards of appointment availability as defined by United's network adequacy standards;

x) Refer for a second opinion as requested by the Covered person, based on Department's guidelines and United's standards;

xi) Review and use Covered Person's utilization and cost reports provided by United for the purpose of Department level utilization management and advise United of errors, omissions, or discrepancies if they are discovered; and

xii) Review and use the monthly enrollment report provided by United for the purpose of participating in United's or practice-based population health or care management activities.

If Provider is a Tier 3 AMH, the requirements set forth in the Department's Advanced Medical Home Policy at Section VII, Attachment M-2 of the State Contract, as may be amended from time to time by the Department, shall apply. Such requirements will be appended to the Agreement if Provider is a Tier 3 AMH.

43 **Local Health Departments.** Providers who are a Local Health Department (LHD) carrying out care management for high-risk pregnancy and for at-risk children agree to comply with the Department's Care Management for High-Risk Pregnancy Policy and Care Management for At-Risk Children Policy found in State Contract Attachments M.4 and 5. The requirements include, but are not limited to:

i) LHDs shall accept referrals from United for Care Management for High-Risk Pregnancy Services and follow all related requirements outlined in State Contract Attachments M.4. These include requirements relating to Outreach, Population Identification and Engagement, Assessment and Risk Stratification, Interventions, Integration with United and Healthcare Providers, Collaboration with United, Training, and Staffing. The specific requirements will be appended to the Agreement if LHD is carrying out care management for high-risk pregnancy.

ii) LHD shall accept referrals from United for children identified as requiring Care Management for At-Risk Children and follow all related requirements outlined in State Contract Attachments M.5. These include requirements relating to Outreach, Population Identification, Family Engagement, Assessment and Stratification of Care Management Service Level, Plan of Care, Integration with United and Healthcare Providers, Service Providers, Training, and Staffing. The specific requirements will be appended to the Agreement if LHD is carrying out care management for At-Risk Children.

iii) LHD shall employ care managers meeting pregnancy care management competencies defined as having at least one of the following qualifications:

- Registered nurses;
- Social workers with a bachelor's degree in social work (BSW, BA in SW, or BS in SW) or master's degree in social work (MSW, MA in SW, or MS in SW) from a Council on Social Work Education accredited social work degree program.
- Bachelor's degree in a human service field with five (5) or more years of care management/case management experience working with the specific population of low-income, pregnant individuals and/or children ages 0-5.
- Bachelor's degree in a human service field with three (3) or more years of care management/case management experience working with the specific population of (low-income, pregnant individuals and/or children ages 0-5) and has certification as a Case Manager (Commission for Case Manager (CCM) Certification preferred).
- Program staff hired prior to September 1, 2011, without a bachelor's or master's degree in social work may retain their existing position only. This grandfathered status does not transfer to any other position.

iv) LHD shall ensure that Community Health workers for Care Manager for High-Risk Pregnancy services work under the supervision and direction of a trained care manager.

v) LHD shall include both registered nurses and social workers in order to best meet the needs of the Target Population with medical and psychosocial risk factors on their team.

vi) If the LHD only has a single Care Manager for High-Risk Pregnancy, the LHD shall ensure access to individual (s) to provide needed resources, consultation and guidance from the non-represented professional discipline.

vii) LHD shall engage care managers who operate with a high level of professionalism and possess an appropriate mix of skills needed to work effectively with a pregnant population at high risk for poor birth outcome. This skill mix should reflect the capacity to address the needs of patients with both medically and socially complex conditions.

viii) LHD shall ensure that Pregnancy Care Managers must demonstrate:

- A high level of professionalism and possess appropriate skills needed to work effectively with a pregnant population at high risk for poor birth outcomes
- Proficiency with the technologies required to perform care management functions
- Motivational interviewing skills and knowledge of adult teaching and learning principles;
- Ability to effectively communicate with families and providers; and
- Critical thinking skills, clinical judgment and problem-solving abilities.

ix) LHD shall provide qualified supervision and support for pregnancy care managers to ensure that all activities are designed to meet performance measures, with supervision to include:

- Provision of program updates to care managers.
- Daily availability for case consultation and caseload oversight.
- Regular meetings with direct service care management staff.
- Utilization of reports to actively assess individual care manager performance.
- Compliance with all supervisory expectations delineated in the Care Management for High- Risk Pregnancy Program Manual.

x) LHD shall establish staffing arrangements to ensure continuous service delivery through appropriate management of staff vacancies and extended absences, including following PHP/Department guidance about communication with PHP about any vacancies or extended staff absences and adhering to guidance about contingency planning to prevent interruptions in service delivery.

xi) Vacancies lasting longer than sixty (60) days shall be subject to additional oversight by PHPs.

Pursuant to the State Contract, United also acknowledges that it shall contract with publicly- funded local health departments to conduct Refugee Health Assessments outlined in Clinical Coverage Policy

1D-1: Refugee Health Assessments Provided in Health Departments.

44 **Mental Health and Substance Use Providers.** Providers who provide Mental Health and Substance Use services to Covered Persons must provide for services to be delivered in compliance with the requirements of 42 CFR 438.3 subpart K insofar as those requirements are applicable.

45 **Long-Term Services and Supports (LTSS) Providers.** Any LTSS Covered Services under the State Contract that could be authorized through a waiver under section 1915(c) of the Social Security Act (the "Act") or a State Program amendment authorized through sections 1915(i) or 1915(k) of the Act must be delivered in settings consistent with 42 C.F.R. § 441.301(c)(4).

46 **Primary Care Providers (PCPs).** Providers who are PCPs agree to perform EPSDT screenings for Covered Persons less than 21 years of age in accordance with State Contract Section V.C.2. Early and Periodic Screening, Diagnostic and Treatment (EPSDT). These include, but are not limited to:

i) Perform, during preventive service visits and as necessary at any visit, oral health assessments, evaluations, prophylaxis and oral hygiene counseling for children under 21 years of age in accordance with the Department's Oral Health Periodicity Schedule;

ii) Refer infant Covered Persons to a dentist or a dental professional working under the supervision of a dentist at age one (1), per requirements of the Department's Oral Health Periodicity Schedule. Note that services provided by a dentist are carved out of Medicaid Managed Care and should be billed to the Medicaid Fee-for-Service program; and

iii) Include all of the components listed in State Contract Section V.C.2.i.iii in each medical screening.

47 **Pharmacy Providers.** As applicable, Providers who are pharmacy providers agree to comply with the following:

i) 340B covered entities, and the entity's 340B contract pharmacies, shall submit National Council for Prescription Drug Programs (NCPDP) code "08" in Basis of Cost Determination field 423-DN or in Compound Ingredient Basis of Cost Determination field 490-UE at the point of sale to identify claims submitted for drugs purchased through the 340B program;

ii) 340B covered entities shall identify outpatient hospital and physician- administered drug claims submitted for drugs purchased through the 340B program using a UD modifier or other claim modifiers defined by the Department. 42 C.F.R. § 438.3(s)(3);

iii) 340B covered entities' written agreements with contracted pharmacies shall specify that contract pharmacies comply with the point-of-sale identification of drugs purchased through the 340B program. 42 C.F.R. § 438.3(s)(3); and

iv) Pharmacy providers that retroactively identify 340B claims, shall resubmit the claims with the appropriate NCPDP 340B claims identification codes. 42 C.F.R. § 438.3(s)(3).

48 **Ambulance Services Providers.** Providers of ambulance services agree to comply with State Program's Clinical Coverage Policy No. 15, NC Medicaid Ambulance Services.

SECTION 5
UNITED REQUIREMENTS

5.1 **Payment.** Consistent with N.C. Gen. Stat. § 58-3-225(f), Provider shall submit all claims with a date of service on or before June 30, 2023, to United for processing and payments within one-hundred-eighty (180) Calendar Days) from the date of covered service or discharge (whichever is later), except for pharmacy point of sale claims which shall be submitted within three-hundred sixty-five (365) Calendar Days of the date of the provision of care. When a Member is retroactively enrolled, United shall not limit the time in which claims may be submitted by Provider to fewer than one hundred eighty (180) Calendar Days from the date of enrollment for health care provider and health care provider facility claims and three hundred sixty-five (365) Calendar Days for pharmacy point of sale claims.

For any claims with a date of service on or after July 1, 2023, Provider shall submit all claims to United for processing and payments within 365 calendar days from the date of covered service or discharge (whichever is later). When a Member is retroactively enrolled, United shall not limit the time in which claims may be submitted by Provider to fewer than three hundred sixty-five (365) Calendar Days from the date of enrollment for health care provider, health care provider facility, or pharmacy point of sale claims.

However, Provider's failure to submit a claim within these timeframes will not invalidate or reduce any claim if it was not reasonably possible for the Provider to submit the claim within that time. In such case, the claim should be submitted as soon as reasonably possible, and in no event, later than one (1) year from the time submittal of the claim is otherwise required.

i) For Medical claims (including behavioral health):

   a) United shall within 18 calendar days of receiving a medical claim notify Provider whether the claim is clean or pend the claim and request from Provider all additional information needed to process the claim.

   b) United shall pay or deny a clean medical claim at lesser of 30 calendar days of receipt of the claim or the first scheduled provider reimbursement cycle following adjudication.

   c) A medical pended claim shall be paid or denied within 30 calendar days of receipt of the requested additional information.

ii) For Pharmacy Claims:

   a) United shall within 14 calendar days of receiving a pharmacy claim pay or deny a clean pharmacy claim or notify Provider that more information is needed to process the claim.

   b) A pharmacy pended claim shall be paid or denied within 14 calendar days of receipt of the requested additional information.

iii) If the requested additional information on a medical or pharmacy pended claim is not submitted within 90 days of the notice requesting the required additional information, United shall deny the claim per § 58-3-225 (d).

iv) United shall reprocess medical and pharmacy claims in a timely and accurate manner as described in this provision (including interest if applicable).

v) If United fails to pay a clean claim in full pursuant to this provision, United shall pay Provider interest. Late Payments will bear interest on the portion of the claim that is late at the annual rate of 18 percent beginning on the date following the day on which the claim should have been paid or was underpaid.

vi) United shall pay the interest from subsections v) and vi) as provided in that subsection and shall not require Provider to request the interest.

United shall also pay Provider pursuant to federal law and regulations, including but not limited to 42 CFR 447.46, 42 CFR 447.45(d)(2), 42 CFR 447.45(d)(3), 42 CFR 447.45(d)(5) and 42 CFR 447.45(d)(6), as applicable and as may be amended from time to time. If a third-party liability exists, payment of claims shall be determined in accordance with federal and/or State third party liability law and the terms of the State Contract. Unless United otherwise requests assistance from Provider, United will be responsible for third party collections in accordance with the terms of the State Contract. The funds used for Provider's payments are government funds.

For a secondary claim from a third-party commercial or Medicare insurance regardless of the date of service on the claim, United shall allow Provider one hundred eighty (180) Calendar Days from the primary insurer's Explanation of Benefits/Remittance Advice date (whether the claim was paid or denied) to file the claim to United. The claim should be submitted electronically, and a copy of the third-party commercial or Medicare insurance EOB/RA should be uploaded as an attachment.

United shall not pay for similar services rendered by providers that are "related to" United more than United pays to providers and subcontractors that are not "related to" United. In this context, "related to" is defined as providers or subcontractors:

i) With a direct or indirect ownership interest or ownership or control interest in United,

ii) An affiliate of United, or

iii) United's management company, as applicable, with a direct or indirect ownership interest or ownership or control interest in a provider or subcontractor.

5.2 Additional Payment Requirements. As applicable to Provider, United agrees to the following reimbursement requirements as outlined in the State Contract. In the event any of the below provisions in the State Contract are changed by the State or Department, those changes will be incorporated automatically into this Appendix.

i) United shall reimburse all in-network primary and specialty care physicians, as well as physician extenders (e.g., nurse practitioners and physician assistants) no less than 100% of their respective Medicaid Fee-for-Service Fee Schedule rate or bundle, as set by the Department, unless United and Provider have mutually agreed to an alternative reimbursement arrangement.

ii) For obstetric services, United shall reimburse in-network physicians and physician extenders no less than 100% of the Medicaid Fee-for-Service rate and this includes reimbursement for the pregnancy risk screening and post-partum visit.

iii) United shall make additional, utilization-based directed payments (AUDP) for certain faculty physicians affiliated with the teaching hospitals for each University of North Carolina medical school.

iv) United shall reimburse all in-network hospitals no less than the applicable Medicaid Fee- for-Service rate ("rate floor") for inpatient and outpatient services and utilize the applicable Fee-for-Service payment methodology, unless United and hospital have mutually agreed to an alternative reimbursement amount or methodology.

v) The applicable rate floor and methodology for inpatient hospital services shall be 100% of the hospital specific Medicaid Fee-for-Service reimbursement rate using the Medicaid Fee-for-Service case weights and outlier methodology.

vi) The applicable rate floor and methodology for outpatient hospital services, including emergency department, shall be the hospital charges multiplied by the hospital-specific Medicaid cost-to-charge ratio published on the Department's website.

vii) United shall make additional, utilization-based, directed payments to in-network hospitals owned by UNC Health Care or Vidant Medical Center as described in the State Contract

viii) United shall reimburse FQHCs and RHCs for covered services at negotiated rates that are no less than rates to be defined by the Department and no less than rates paid to other providers for similar services in accordance with 1903(m)(2)(A)(ix) of the Social Security Act.

ix) United shall reimburse IHCP for those that are not FQHC, regardless of whether they participate in United's network, the applicable encounter rate published annually in the Federal Register by IHS or the Medicaid Fee-for-Service rate for services that do not have an applicable encounter rate.

x) United shall reimburse enhanced role registered nurses providing EPSDT well child exams, low-risk family planning, and obstetrical services according to the enhanced local health department Medicaid fee schedule.

xi) United shall make AUDPs in addition to base reimbursement amounts as directed in the State Contract.

xii) United shall reimburse in-network LHDs providing lab services at no less than 100% of the Medicare fee schedule unless United and LHD have mutually agreed to an alternative reimbursement arrangement.

xiii) In addition to base reimbursements, United shall make additional utilization-based payments to in-network public ambulance providers for Covered Persons only, as outlined in the State Contract provision relating to directed payments.

xiv) United shall make additional directed payments as determined by the Department, to certain in-network providers. This includes, but may not be limited to, LHDs, public ambulance providers, certain faculty physicians affiliated with the teaching hospitals for each University of North Carolina medical school, and hospitals owned by UNC Health Care or Vidant Medical Center.

xv) United shall include the Department defined additional directed payments in its contracts

with applicable providers.

xvi) For a period of time to be defined by the Department, United shall reimburse in- network nursing facilities (excluding those owned and operated by the State) a rate that is no less than the Medicaid Fee-for-Service rate in effect six (6) months prior to the start of the capitation rating year (e.g., January 1 prior to a July 1 rating year), unless United and provider have mutually agreed to an alternative reimbursement arrangement.

xvii) United shall reimburse for hospice services in accordance with section 1902(a)(13)(B) of the Social Security Act and state requirements including that the rates shall be no less than the annual federal Medicaid hospice rates (updated each federal fiscal year (FFY).

xviii) For hospice services provided to Covered Persons residing in nursing facilities, United shall reimburse the hospice provider the hospice rate and 95% of the Medicaid nursing home Fee-for-Service room and board rate in effect at the time of services.

xix) Lesser of logic pricing rules should not be applied to the reimbursement of providers by United for any programs/services that State or Department has established an applicable rate floor unless United and the provider have mutually agreed to an alternative reimbursement arrangement. United's reimbursement of providers for any programs/services that NC Medicaid has not established an applicable rate floor are negotiable regarding the application of lesser of logic pricing rules.

xx) For purposes of claims payment, United shall be deemed to have paid the claim as of the Date of Payment, and United shall be deemed to have denied the claim as of the date the remittance advice is sent to Provider. United defines Date of Payment as either the date of Electronic Funds Transfer (EFT) to Provider or the date a paper check is mailed to Provider.

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

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

5.5 Communications with Covered Persons. United shall not prohibit or otherwise restrict Provider, when acting within the lawful scope of practice, from advising or advocating on behalf of a Covered Person for the following:

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

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

treatment options;

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

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

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

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

5.7 Eligibility Verification. Pursuant to the State Contract, United will provide a mechanism that allows Provider to verify Covered Person eligibility, based on current information held by United, before rendering covered services. The administrative guide located at www.uhcprovider.com will describe that mechanism(s).

5.8 Data to Provider. United agrees to provide data and information to the Provider as required by the State Contract, including:

i) Performance feedback reports or information to the Provider, if compensation is related to efficiency criteria;

ii) Information on benefit exclusions; administrative and utilization management requirements; credential verification programs; quality assessment programs; and provider sanction policies;

iii) Notification of changes in these requirements shall also be provided by the United, allowing Provider time to comply with these changes.

5.9 Ambulance Services. United agrees to comply with the State Program's Clinical Coverage Policy No. 15, NC Medicaid Ambulance Services.

5.10 Previous Authorizations for Outpatient Procedures. United shall accept retroactive requests for authorization of outpatient procedures in those instances where, in accordance with generally accepted North Carolina community practice standards and meeting the North Carolina Medicaid Medical Necessity Standard, an authorized outpatient procedure was modified or supplemented as a result of clinical findings or outcomes arising during the authorized outpatient procedure. Provider shall submit such retroactive requests for authorization within three (3) business days of concluding the authorized outpatient procedure.

5.11 Physician Advisor Use in Claims Dispute. United shall accept Provider's designated, North Carolina licensed, physician advisor with knowledge of the unit and care of the Member as Provider's approved representative for a claim or prior authorization in review or dispute.

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 United has provided or delivered to Provider. The applicable provisions of the State Contract are incorporated into the Agreement by reference. Nothing in the Agreement relieves United of its responsibility under the State Contract. If any provision of the Agreement is in conflict with provisions of the State Contract, the terms of the State Contract shall control and the terms of the Agreement in conflict with those of the State Contract will be considered waived.

6.2 **Monitoring.** United 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, United shall identify to Provider any deficiencies or areas for improvement mandated under the State Contract and Provider and United shall take appropriate corrective action. Provider shall comply with any corrective action plan initiated by United and/or required by the State Program. In addition, Provider shall monitor and report the quality of service delivered under the Agreement and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which United and Provider practice and/or the performance standards established under the State Contract.

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

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

6.5 **Delegation.** Any delegated duties and reporting responsibilities shall be set forth in the Agreement or other written delegation agreement or addendum between the parties. United shall notify Provider, in writing, of any duties or obligations that are to be delegated or transferred, before the delegation or transfer.

6.6 **Term of Agreement.** The term of the Agreement, as it relates to State Program, shall not exceed the term of the State Contract. Accordingly, parties agree the term of the Agreement, as it relates to State Program, shall have the same duration of the State Contract. However, parties may terminate the Agreement pursuant to the termination provisions in the Agreement, including applicable notice provisions. To the extent required by the State Contract, United and Provider agree to include the reasons or basis the Agreement may be terminated or non-renewed.

6.7 **Provider Directory.** The parties acknowledge and agree that the Provider shall be listed in the provider directory distributed to Covered Persons.

6.8 **Chapter 58 Requirements.** As applicable, the parties agree to comply with the following North Carolina General Statutes and subsections:

i) G.S. 58-3-200(c). If United determines that services, supplies, or other items are covered under its health benefit plan, including any determination under G.S. 58- 50-61 , United shall not subsequently retract its determination after the services, supplies, or other items have been provided, or reduce payments for a service, supply, or other item furnished in reliance on such a determination, unless the determination was based on a material misrepresentation about the Covered Person's health condition that was knowingly made by Covered Person or Provider.

ii) G.S. 58-3-227 (h) (see also Section 2.H for a prescribed provision related to this statute). When United offers a contract to Provider, United shall also make available its schedule of fees associated with the top 30 services or procedures most commonly billed by that class of provider. Upon the request of Provider, United shall also make available the full schedule of fees for services or procedures billed by that class of provider or for each class of provider in the case of a contract incorporating multiple classes of providers. If Provider requests fees for more than 30 services and procedures, United may require Provider to specify the additional requested services and procedures and may limit Provider's access to the additional schedule of fees to those associated with services and procedures performed by or reasonably expected to be performed by Provider.

iii) G.S. 58-50-270(1), (2), and (3). Unless the context clearly requires otherwise, the following definitions apply to the Agreement.

a) **Amendment:** Any change to the terms of a contract, including terms incorporated by reference, that modifies fee schedules. A change required by federal or State law, rule, regulation, administrative hearing, or court order is not an amendment.

b) **Contract:** An agreement between an insurer and a health care provider for the provision of health care services by the provider on a preferred or in-network basis.

c) **Health benefit plan:** A policy, certificate, contract, or plan as defined in G.S. 58-3-167.

d) G.S. 58-50-275 (a) and (b). The Agreement shall contain a “notice contact” provision listing the name or title and address of the person to whom all correspondence, including proposed amendments and other notices, pertaining to the contractual relationship between parties shall be provided. Each party to a contract shall designate its notice contact under such Agreement. Means for sending all notices provided under the Agreement shall be one or more of the following, calculated as (i) five business days following the date the notice is placed, first-class postage prepaid, in the United States mail; (ii) on the day the notice is hand delivered; (iii) for certified or registered mail, the date on the return receipt; or (iv) for commercial courier service, the date of delivery. Nothing in this section prohibits the use of an electronic medium for a communication other than an amendment if agreed to by United and Provider.

e) G.S. 58-50-280 (a) through (d). United shall send any proposed contract amendment to the notice contact of Provider pursuant to N.C.G.S. 58-50-275. The proposed amendment shall be dated, labeled "Amendment," signed by United, and

include an effective date for the proposed amendment. Provider shall be given at least 60 days from the date of receipt to object to the proposed amendment. The proposed amendment shall be effective upon Provider failing to object in writing within 60 days. If a Provider objects to a proposed amendment, then the proposed amendment is not effective and United shall be entitled to terminate the contract upon 60 days written notice to Provider. Provider and United may negotiate contract terms that provide for mutual consent to an amendment, a process for reaching mutual consent, or alternative notice contacts.

f) G.S. 58-50-285 (a) and (b). United shall provide a copy of its policies and procedures to Provider prior to execution of a new or amended contract and annually. Such policies and procedures may be provided to Provider in hard copy, CD, or other electronic format, and may also be provided by posting the policies and procedures on United's website www.uhcprovider.com). The policies and procedures of United shall not conflict with or override any term the Agreement, including contract fee schedules. In the event of a conflict between a policy or procedure and the language in the Agreement, the Agreement language shall prevail.

g) G.S. 58-51-37 (d) and (e).As applicable to providers who are pharmacy providers, a pharmacy, by or through a pharmacist acting on its behalf as its employee, agent, or owner, may not waive, discount, rebate, or distort a copayment of any insurer, policy, or plan, or a beneficiary's coinsurance portion of a prescription drug coverage or reimbursement and if a pharmacy, by or through a pharmacist's acting on its behalf as its employee, agent or owner, provides a pharmacy service to an enrollee of a health benefit plan that meets the terms and requirements of the insurer under a health benefit plan, the pharmacy shall provide its pharmacy services to all enrollees of that health benefit plan on the same terms and requirements of the insurer. A violation of this subsection shall be a violation of the Pharmacy Practice Act subjecting the pharmacist as a licensee to disciplinary authority of the North Carolina Board of Pharmacy pursuant to G.S. 90-85.38. At least 60 days before the effective date of any health benefit plan providing reimbursement to North Carolina residents for prescription drugs, which restricts pharmacy participation, the entity providing the health benefit plan shall notify, in writing, all pharmacies within the geographical coverage area of the health benefit plan and offer to the pharmacies the opportunity to participate in the health benefit plan. All pharmacies in the geographical coverage area of the plan shall be eligible to participate under identical reimbursement terms for providing pharmacy services, including prescription drugs. The entity providing the health benefit plan shall, through reasonable means, on a timely basis, and on regular intervals in order to effectuate the purposes of this section, inform the beneficiaries of the plan of the names and locations of pharmacies that are participating in the plan as providers of pharmacy services and prescription drugs. Additionally, participating pharmacies shall be entitled to announce their participation to their customers through a means acceptable to the pharmacy and the entity providing the health benefit plans. The pharmacy notification provisions of this section shall not apply when an individual or group is enrolled, but when the plan enters a particular county of the State.

69 **Dispute Resolution.** United agrees contractual differences with Provider shall be resolved via a process that is compliant with the State Contract, including the guidelines on Provider Grievance and Appeals as found in Section V.D.5. Provider Grievances and Appeals. United agrees to handle

provider appeals and grievances promptly, consistently, fairly, and incompliance with state and federal law and Department requirements. United shall have in place a provider appeals and grievance system, distinct from that offered to Covered Persons, that includes a grievance process for providers to bring issues to United, an appeals process for Provider to challenge certain United decisions, and information regarding access to a state level review through the Office of Administrative hearings. United shall be transparent with providers regarding its appeals and grievance processes and procedures. United shall submit United's Provider Grievances and Appeals Policy to the Department for review 120 days after Contract Award. United shall submit any significant policy changes to the Department for review at least 60 calendar days before implementing the changes. United shall have a process to and staff capable of reviewing provider Grievance and Appeal outcomes to identify trends, review existing operational or clinical opportunities to improve the provider experience.

The administrative guide located at www.uhcprovider.com will describe applicable grievance and appeal process(es). Provider agrees to complete all applicable grievance and appeal processes before seeking other legal or administrative remedies under State or federal law.

6.10 Escalators. As provided in the State Contract, the parties agree that United shall not include a rate methodology that provides for an automatic increase in rates. In addition, if the Department requires that compensation for a Covered Service be no less than a specified minimum amount under the NC Medicaid fee schedule, United shall reimburse Provider accordingly for such Covered Service unless otherwise agreed upon by the parties.

6.11 Payments Outside the United States. United and Provider shall annually certify that no payments are made for services or items provided to a provider, subcontractor, or financial institution located outside of the United States relating to the State Contract.

6.12 Certifications and Representations. Provider shall certify annually pursuant to 42 C.F.R. § 200.209 Certifications and Representations that it is in compliance with federal certification and representation requirements regarding Nondiscrimination, Drug-Free Workplace Requirements, Environmental Tobacco Smoke, Debarment, Suspension, Ineligibility and Voluntary Exclusion Lower Tier Covered Transactions and Lobbying.

Provider shall certify annually that it is in compliance with state certification requirements regarding Verification of Employee Work Authorization, Ineligibility, Prior Convictions and Prior Employment.

6.13 Critical Incident Reporting. Category A and B Providers, as those terms are defined in 10A NCAC 27G .0602(8), shall report Level II and III incidents, as those terms are defined in 10A NCAC 27G .0602(4) and (5), in the NC Incident Response Improvement System.