

AMERIHEALTH CARITAS NORTH CAROLINA, INC.

PHYSICIAN PROVIDER AGREEMENT

With

Guilford County Health Department

**AMERIHEALTH CARITAS NORTH CAROLINA, INC.
PHYSICIAN PROVIDER AGREEMENT**

This Physician Provider Agreement (the “Agreement”), dated as of the Effective Date (defined below), is made by and between **AmeriHealth Caritas North Carolina, Inc.**, a corporation organized under the laws of the State of North Carolina, (hereinafter referred to as (“ACNC”)” and the Provider (“Provider”) identified on the signature page.

WHEREAS, ACNC is a managed care organization that is responsible for providing or arranging for the provision of health care services to its Members; and

WHEREAS, Provider and ACNC mutually desire to enter into this Agreement, whereby Provider shall render services to Members enrolled with ACNC and be compensated by ACNC in accordance with the terms and conditions hereof.

NOW, THEREFORE, in consideration of the mutual promises made herein, it is mutually agreed by and between ACNC and Provider as follows:

1. DEFINITIONS

As used in this Agreement, each of the following terms shall have the meaning specified herein, unless the context clearly requires otherwise.

- 1.1 **AFFILIATES.** An Affiliate is any corporation or other organization that is identified as an Affiliate in a written notice to Provider and is owned or controlled, either directly or through parent or subsidiary corporations, by or under common control with, ACNC shall give Provider thirty (30) days advance written notice of the addition of Affiliates added under this provision. Unless otherwise specified in this Agreement or any other attachment hereto, references to “ACNC” shall include the Affiliates referenced in **Appendix D**.
- 1.2 **AGENCY.** The State and/or Federal governmental agency that administers the Program(s) under which ACNC is obligated to provide or arrange for the provision of Covered Services.
- 1.3 **AGENCY CONTRACT.** The contract or contracts between ACNC and the Agency, as in effect from time to time, pursuant to which ACNC is responsible for coordinating health care services and supplies for Program recipients enrolled with ACNC.
- 1.4 **CLEAN CLAIM.** A claim for payment for a health care service, which has been received by ACNC, has no defect or impropriety. A defect or impropriety shall include a lack of required substantiating documentation or a particular circumstance requiring special treatment that prevents timely payment from being made on the claim. Consistent with **42 CFR §447.45(b)**, the term shall not include a claim from a health care provider who is under investigation for fraud or abuse regarding that claim, or a claim under review for medical necessity.
- 1.5 **COVERED SERVICES.** Those Medically Necessary health care services and supplies to which Members are entitled pursuant to the Agency Contract, and which shall be provided to Members by Provider, as described more specifically in **Appendix A**. Covered Services shall be furnished in the amount, duration and scope required under the Program.

- 1.6 **EFFECTIVE DATE.** The later of (i) the effective date on the signature page of this Agreement or (ii) the effective date of the Agency Contract, provided that Provider has been successfully credentialed by ACNC and that all required regulatory approvals have been obtained by ACNC.
- 1.7 **EMERGENCY MEDICAL CONDITION.** Health care services provided to a Member after the sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity or 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:
- (a) Placing the health of the Member (or with respect to a pregnant woman, the health of the Member or her unborn child) in serious jeopardy;
 - (b) Serious impairment to bodily functions; or
 - (c) Serious dysfunction of any bodily organ or part.
- 1.8 **EMERGENCY SERVICES.** Covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish these services under 42 C.F.R. Section 438.114(a) and 42 U.S.C. Section 1932(b)(2) and that are needed to screen, evaluate, and stabilize an Emergency Medical Condition.
- 1.9 **GROUP PHYSICIAN.** A physician who practices with Provider as an employee, partner, shareholder, or contractor.
- 1.10 **MEDICALLY NECESSARY.** 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.
- 1.11 **MEMBER.** An individual that is eligible for a Program and who has enrolled in ACNC under the Program.
- 1.12 **MEMBER APPEAL PROCEDURES.** The written procedures describing ACNC's standards for the prompt resolution of Member problems, grievances and appeals, as described in the Provider Manual.
- 1.13 **PARTICIPATING PROVIDER.** A physician duly licensed to practice medicine in the State of North Carolina participating in or eligible to participate in the North Carolina Medicaid program, and who is a member of the medical staff of a(n) ACNC- participating hospital, or a licensed, appropriately supervised allied health professional, either of whom has entered into, or who is recognized by ACNC as a member of a group which has entered into, an agreement with ACNC to provide medical services to Members under the Program.
- 1.14 **PRIMARY CARE PROVIDER.** A duly licensed pediatrician, internist, family practitioner, or doctor of general medicine, obstetrician/gynecologist or group thereof or a licensed, appropriately supervised allied health professional, who has been successfully credentialed by, and is a Participating Provider with ACNC, and who is responsible for the supervision, coordination, and provision of primary care services to Members who have selected, or have been assigned to, that provider. The Primary Care Provider also is responsible for initiating any required referrals for specialty care needed by a Member and maintaining overall continuity of a Member's care.

- 1.15 **PRIMARY CARE SERVICES.** Covered Services specified in **Appendix A** hereto and any additional services specified as Primary Care Services in the Provider Manual, as updated or amended from time to time. All Covered Services shall be provided in the amount, duration and scope set forth in the State Contract and as otherwise required under the Program.
- 1.16 **PROGRAM.** The Medicaid managed care model of the North Carolina Medicaid and NC Health Choice programs.
- 1.17 **PROVIDER MANUAL.** The ACNC manual of standards, policies, procedures and corrective actions together with amendments or modifications ACNC may adopt from time to time. The Provider Manual is herein incorporated by reference and made part of this Agreement. The Provider Manual may be amended or modified by ACNC from time to time in accordance with Section 4.8 herein below.
- 1.18 **QUALITY MANAGEMENT PROGRAM.** An ongoing review process and plan which functions to define, monitor, review, and recommend corrective action for managing and improving the quality of health care services to Members.
- 1.19 **SPECIALTY CARE PROVIDER.** A duly licensed physician who has been successfully credentialed by ACNC and who has entered into an agreement to provide Specialty Care Services to Members in accordance with the referral and preauthorization requirements of the Provider Manual.
- 1.20 **SPECIALTY CARE SERVICES.** Covered Services specified in **Appendix A** hereto and any additional specified as “Specialty Care Services” in the Provider Manual, as updated and amended from time to time.
- 1.21 **UTILIZATION MANAGEMENT PROGRAM.** A process of review of the medical necessity, appropriateness and efficiency of health care services, procedures, equipment, supplies, and facilities rendered to Members.

2. SERVICES:

- 2.1 Provider agrees to provide and cause its Group Physicians to provide, as applicable, (i) Primary Care Services to Members who have selected, or are otherwise assigned to, Provider as their Primary Care Provider, and (ii) Specialty Care Services to Members who have been referred to Provider. Covered Services shall be provided in accordance with the terms of this Agreement and ACNC referral, preauthorization and other Utilization Management Program policies as described in the Provider Manual, other than Emergency Services, which will be provided as needed. Provider will refer Members to providers participating in the ACNC network whenever Provider is unable to provide Medically Necessary services and/or when consistent with sound medical judgment and accepted standards of care. Provider and Group Physicians shall provide such services in the same manner and with the same availability as services provided to other patients without regard to reimbursement and shall further provide these services in accordance with the clinical quality of care and performance standards which are professionally recognized as industry practice and/or otherwise adopted, accepted or established by ACNC.
- 2.2 Provider will deliver office-based medical services to Members only at those office locations set forth in **Appendix B** hereto as such appendix is modified from time to time by mutual agreement of the parties. Provider shall notify ACNC at least sixty (60) days prior to making any addition or change to office locations.

- 2.3 Primary Care Providers shall accept as patients those Members who have selected or have been assigned to Provider, and Specialty Care Providers shall accept as patients those Members who have been referred to Provider, in either case without regard to the health status or medical condition of such Members. Primary Care Providers may decline to accept additional Members (excluding persons already in Provider's practice that enroll in ACNC) by giving ACNC written notice of such intent ninety (90) days in advance of the effective date of such closure. Provider agrees to accept any Members selecting the Primary Care Provider's practice during the ninety (90) day notice period.
- 2.4 Provider shall provide ACNC with complete and accurate statements of all Covered Services provided to Members in conformance with ACNC billing procedures, including without limitation, use of complete applicable diagnosis, procedure and revenue codes. ACNC will not be liable for any bills relating to services that are submitted the later of: (a) after twelve (12) months from the date the services were provided (consistent with **42 CFR §447.45(d)**), or (b) after sixty (60) days of the date of the Explanation of Benefits from another payor when services are first billed by Provider to another payor. Any appeal or request for adjustment of a payment by Provider must be made in accordance with applicable provisions of the Provider Manual and ACNC policies and procedures and, in any case, must be received by ACNC within sixty (60) days of the original payment or denial. Provider may not bring legal action on claims which have not been appealed through the appeal mechanisms described herein.

Encounter Data and Other Reports. Provider shall deliver all reports and clinical information required to be submitted to ACNC pursuant to this Agreement for reporting purposes, including but not limited to encounter data, Healthcare Effectiveness Data and Information Set (HEDIS), Agency for Healthcare Research and Quality (AHRQ), and EPSDT data in a format which will allow ACNC to transmit required data to the Agency electronically and in a format identical to or consistent with the format used or otherwise required by ACNC and the Agency. Provider shall submit this information to ACNC within the time frames set forth in the Provider Manual or as otherwise required by the Agency. Provider shall submit all encounter data to the same standards of completeness and accuracy as required for proper adjudication of fee-for-service claims by ACNC.

- 2.5 In accordance with ACNC policies and procedures, only successfully credentialed Participating Providers may provide Covered Services to Members under this Agreement.

3. COMPENSATION:

- 3.1 ACNC shall pay Provider for Covered Services provided to Members pursuant to the terms of this Agreement. ACNC shall have the right to offset claims payments to Provider by any amount owed by Provider to ACNC, following at least thirty (30) days' written notice. Provider shall not be entitled to reimbursement if the Member was not eligible at the time services were rendered.
- 3.2 ACNC agrees to pay Provider the amount set forth in **Appendix C** for Covered Services rendered by Provider to Members. Provider understands and agrees that any payments ACNC makes directly or indirectly to Provider under this Agreement shall not be made as an inducement to reduce, limit, or delay Medically Necessary Covered Services to any Member. Except as may be otherwise specifically set forth in **Appendix C**, in no event will ACNC's payment exceed submitted charges. Provider recognizes and accepts the fees set forth in **Appendix C** as payment in full, and no additional charges will be made by Provider to ACNC for Covered Services provided hereunder.

- 3.3 Under no circumstances, including ACNC's failure to pay for Covered Services, termination of this Agreement, or the insolvency of ACNC, will Provider or any Group Physician bill or collect from, or make any charges or claims against any Member directly or indirectly for Covered Services authorized by ACNC, except for authorized co-payments, co-insurance and/or deductible. Provider and Group Physicians shall look only to ACNC for compensation for Covered Services. Provider shall not deny Covered Services to a Member in the event that a Member is unable to pay any authorized co-payment amounts. **42 CFR §447.15.**
- 3.4 Provider may directly bill Members for non-Covered Services if the Member is advised in writing before the service is rendered of: (i) the nature of the service(s) to be rendered; (ii) that ACNC does not cover the services; and (iii) that the Member will be financially responsible for the services if the Member elects to receive the services. Furthermore, Provider shall hold harmless ACNC for any claim or expense arising from such services.
- 3.5 ACNC shall pay all Clean Claims for Covered Services in accordance with applicable laws, regulations and Agency requirements; and ACNC will in any event meet the claim payment timeframes required under **42 CFR §447.45(d)**. ACNC will establish payment policies, including but not limited to the application of claim edits. In its processing of claims, ACNC will apply claim edits based on sources that include CMS and state-specific policy, as set forth in the Provider Manual.

4. ADMINISTRATION:

- 4.1 Throughout the term of this Agreement, Provider and all Group Physicians shall: (a) have and maintain, without restriction, all licenses, certificates, registrations and permits as are required under applicable State and federal statutes and regulations to provide the Covered Services furnished by Provider and/or other related activities delegated by ACNC under this Agreement. Provider shall obtain a unique identifier (national provider identifier) in accordance with the system established under Section 1173(b) of the Social Security Act, submit such identifier number to ACNC, and include such identifier on all claims. At all times during the term of this Agreement, Provider shall be eligible for participation in the North Carolina Medicaid program; and, if required by the North Carolina Medicaid program as a condition of furnishing services to North Carolina Medicaid recipients, Provider shall participate in the North Carolina Medicaid program. To the extent that Covered Services are furnished to Medicare beneficiaries under this Agreement, Provider shall also participate in the Medicare program. Provider shall ensure that all services provided pursuant to this Agreement are within the Provider's and, if applicable, Group Physicians' scope of professional responsibility.
- 4.2 During the term of this Agreement and in the event of termination of this Agreement for any reason, Provider and its Group Physicians will fully cooperate with each Member and with ACNC in arranging for the transfer of copies of Member medical records to other Participating Providers.
- 4.3 Record Maintenance, Inspection, Reporting and Auditing.
- (a) Record Retention. As required by **42 CFR 434.6(a)(7)** and otherwise in accordance with the standards of ACNC, Provider and Group Physicians shall maintain an adequate record system for recording services, service providers, charges, dates and all other commonly required information elements for services rendered to Members pursuant to this Agreement (including but not limited to such records as are necessary for the evaluation

of the quality, appropriateness, and timeliness of services performed under this Agreement and the Agency Contract).

- (b) All records originated or prepared in connection with Provider's performance of its obligations under this Agreement will be retained and safeguarded by Provider in accordance with the terms and conditions of the Agency Contract and other relevant State and federal law. Provider agrees to retain all financial and programmatic records, supporting documents, statistical records and other records of Members relating to the delivery of care or service under the Agency Contract and as further required by the Agency, for a period of no less than ten (10) years from the expiration date of the Agency Contract, including any contract extension(s). If any audit, litigation, claim, or other actions involving the records have been initiated prior to the expiration of the ten (10) year period, the records shall be retained until completion of the action and resolution of all issues which arise from it or until the end of the ten (10) year period, whichever is later. If Provider stores records on microfilm or microfiche or other electronic means, Provider agrees to produce, at its expense, legible hard copy records promptly upon the request of state or federal authorities.
 - (c) Medical Record Maintenance. Provider shall ensure that all medical records are in compliance with the medical record keeping requirements set forth in the Provider Manual, the Agency Contract and Agency guides. Provider shall maintain up-to-date medical records at the site where medical services are provided for each Member enrolled under this Agreement. Each Member's record must be accurate, legible and maintained in detail consistent with good medical and professional practice which permits effective internal and external quality review and/or medical audit and facilitates an adequate system of follow-up treatment.
 - (d) ACNC shall be entitled to audit, examine and inspect Provider's books and records, including but not limited to medical records, financial information and administrative information pertaining to Provider's relationship with ACNC, at any time during normal business hours, upon reasonable notice. Provider agrees to provide ACNC, at no cost to ACNC, with such medical, financial and administrative information, and other records as may be necessary for ACNC to meet its obligations related to the Agency Contract and other regulatory obligations, Utilization Management Program and Quality Management Program standards, including NCQA standards, and other relevant accreditation standards which ACNC may require of ACNC participating providers.
- 4.4. Whether announced or unannounced, Provider agrees to, and shall cause its Group Physicians to, cooperate with, participate in, and abide by internal or external quality assessment reviews, Member Appeal Procedures, Utilization Management Program procedures, and Quality Management Program procedures established by ACNC, and to follow practice guidelines as described in the Provider Manual, the Agency Contract and the applicable Program manuals. Provider shall permit a representative of ACNC, or its designee, to review medical records concurrently as well as retrospectively. Provider shall provide copies of such medical records, either in paper or electronic form, to ACNC or its designee upon request. The Utilization Management and Quality Management Programs are described in the Provider Manual.
- 4.5 Provider authorizes ACNC to include Provider's and its Group Physicians' name(s), address(es), telephone number(s), medical specialty(ies), hospital affiliations, and other similar information relevant to Provider and/or Group Physicians, Provider's operations and its staff in the ACNC provider directory and in various marketing materials identifying Provider and/or Group Physicians

as a provider(s) of services to Members. Provider agrees to afford ACNC the same opportunity to display brochures, signs, or advertisements in Provider's office(s) as Provider affords any other insurance company or other third party payor.

4.6 While both parties support Provider's open and active communication with Members concerning Medically Necessary services, available treatment alternatives, benefit coverage information and/or any other information pertaining to the provider-patient relationship, neither Provider nor any of its Group Physicians shall, during the term of this Agreement, and any renewal thereof, solicit or require any Member, either orally or in writing, to subscribe to or enroll in any managed care plan other than ACNC. The provisions of this **Section 4.6** shall similarly apply to Provider's employees, agents and/or contractors (including all Group Physicians).

4.7 Provider shall cooperate with ACNC in the identification of other sources of payment available to Members, such as other health insurance, government programs, liability coverage, motor vehicle coverage or worker's compensation coverage, as applicable. Provider shall be responsible for reporting all applicable third party resources to ACNC in a timely manner.

Provider will cooperate with ACNC in coordinating benefits with other payors in accordance with coordination of benefits claim processing rules and requirements outlined in the Provider Manual, the Agency Contract and applicable Program manuals, as amended from time to time. Provider will make a reasonable attempt to determine whether any other payor has primary responsibility for the payment of a claim for services that Provider rendered to a Member and bill that payor before billing ACNC. Unless otherwise prohibited by applicable law, ACNC retains the right to recover payments made to Provider if ACNC determines that another payor is primarily responsible for all or a portion of the claim.

4.8 ACNC shall furnish or otherwise make available to Provider a copy of the Provider Manual, as amended from time to time. Provider Manual updates will become effective thirty (30) days from the date of notification, unless otherwise specified in writing by ACNC.

4.9 ACNC 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 the Provider practices and/or the standards established by ACNC, the Agency, or their respective designees. Provider shall cooperate with and abide by any corrective action plan initiated by ACNC and/or required by the Agency or any other State or federal regulatory agency with governing authority over the services provided under this Agreement.

4.9 Provider agrees that to the extent penalties, fines or sanctions are assessed against ACNC by the Agency or another regulatory agency with governing authority over the services provided under this Agreement as a result of Provider's or any Group Physician's failure to comply with their respective obligations under this Agreement, including but not limited to, failure or refusal to respond to the Agency's request for medical records, credentialing information, and other information required to be provided under this Agreement, Provider shall be responsible for the immediate payment of such penalties, fines or sanctions. In the event such payment is not made in a timely manner to ACNC, ACNC shall have the right to offset claims payments to Provider by the amount owed by Provider to ACNC.

4.10 Provider will assist ACNC in providing orientation services to Provider staff, to the extent ACNC may reasonably request.

- 4.11 Fraud and Abuse. Provider recognizes that payments made by ACNC pursuant to this Agreement are derived from federal and State funds, and acknowledges that it may be held civilly and/or criminally liable to ACNC and/or the Agency, in the event of non-performance, misrepresentation, fraud or abuse for services rendered to Members, including but not limited to, the submission of false claims/statements for payment by Provider, its employees or agents. Provider shall be required to comply with all policies and procedures as developed by ACNC and the Agency, including but not limited to the requirements set forth in the Provider Manual and the Agency Contract, for the detection and prevention of fraud and abuse. Such compliance may include, but not be limited to, referral of suspected or confirmed fraud or abuse to ACNC.
- 4.12 Provider Protections.
- (a) ACNC shall not exclude or terminate Provider or a Group Physician from ACNC's provider network because the Provider or Group Physician advocated on behalf of a Member including in the context of a utilization management appeal or another dispute with ACNC over appropriate medical care, provided that such advocacy is consistent with the degree of learning and skill ordinarily possessed by a health care provider practicing in accordance with the applicable standard of care.
 - (b) Provider shall not be excluded or terminated from participation with ACNC due to the fact that the Provider may have a practice that includes a substantial number of patients with expensive medical conditions.
 - (c) Provider shall not be excluded from participation, nor shall this Agreement be terminated, because Provider objects to the provision of or refuses to provide a healthcare service on moral or religious grounds.

5. PROFESSIONAL LIABILITY INSURANCE/ADVERSE ACTIONS:

- 5.1 Provider, at his/her sole expense, shall provide professional liability, comprehensive general liability, and medical malpractice insurance coverage (including coverage for vicarious liability, if any, for the acts of employees, agents and representatives of Provider (including without limitation all Group Physicians)) upon execution of this Agreement and at all times during the term of this Agreement, as follows:
- (a) Amounts and extent of such insurance coverage as deemed necessary by ACNC to insure against any claim or claims for damages arising by reason of personal injury or death occasioned, directly or indirectly, in connection with Provider's performance of any service pursuant to this Agreement; in no event shall such coverage be less than the amounts required by law.
 - (b) Provider shall provide ACNC with written verification of the existence of such coverage upon execution of this Agreement and as otherwise requested by ACNC throughout the term of the Agreement, which may include providing copies of face sheets of such coverage. Provider shall notify ACNC reasonably in advance of any change or cancellation of such coverage.
- 5.2 Provider shall immediately notify ACNC in writing, by certified mail, of any written or oral notice of any adverse action, including, without limitation, litigation, investigation, complaint, claim or transaction, regulatory action or proposed regulatory action, or other action naming or otherwise involving Provider or a Group Physician, or any other event, occurrence or situation which may reasonably be considered to have a material impact on Provider's or a Group Physician's ability to

perform Provider's duties or obligations under this Agreement. Provider also shall immediately notify ACNC of any action against any applicable license, certification or participation under Title XVIII or other applicable provision of the Social Security Act or other State or federal law, State and/or DEA narcotic registration certificate, or medical staff privileges at any facility, and of any material change in the ownership or business operations of Provider or a Group Physician. All notices required by this Section 5.2 shall be furnished as provided in Section 10.6 of this Agreement.

- 5.3 Provider agrees to defend, indemnify and hold harmless ACNC and its officers, directors and employees from and against any and all claims, costs and liabilities (including the fees and expenses of counsel) as a result of a breach of this Agreement by Provider, the negligent or willful misconduct of Provider and/or Provider's employees, agents and representatives (including without limitation Group Physicians), and from and against any death, personal injury or malpractice arising in connection with the performance of any services by the Provider and all Group Physicians in connection with this Agreement. This section shall survive the termination or expiration of this Agreement for any reason.

ACNC agrees to defend, indemnify and hold harmless Provider and its officers, directors and employees from and against all claims, costs and liabilities (including the fees and expenses of counsel) as a result of ACNC's breach of this Agreement or the negligent or willful misconduct of ACNC and/or ACNC's employees, agents and representatives in connection with ACNC's performance under this Agreement. This section shall survive the termination or expiration of this Agreement for any reason.

6. CONFIDENTIALITY:

ACNC and Provider shall each comply with all applicable State and federal laws respecting the confidentiality of the medical, personal or business affairs of Members acquired in the course of providing services pursuant to this Agreement. Each party shall maintain as confidential and shall not disclose to third parties financial, operating, proprietary or business information relating to the other party which is not otherwise public information. The payment rates in this Agreement are confidential and proprietary and shall not be disclosed by either party. However, nothing herein shall prohibit either party from making any disclosure or transmission of information to the extent that such disclosure or transmission is required by CMS or an applicable state regulatory agency, or is necessary or appropriate to enable the disclosing party to perform its obligations or enforce its rights under this Agreement, or is required by law or legal process. Should disclosure be required by law or legal process, the disclosing party shall immediately notify the other party of the disclosure.

7. COOPERATION; RESOLUTION OF DISPUTES:

- 7.1 Cooperation. To the extent compatible with separate and independent management of each, ACNC and Provider shall at all times maintain an effective liaison and close cooperation with each other to provide maximum benefits to Members at the most reasonable cost consistent with high standards of care. ACNC and Provider shall use best efforts to exchange information regarding material matters directly or indirectly related to this Agreement.
- 7.2 Resolution of Disputes. ACNC and Provider shall both fully cooperate in resolving any and all controversies among or between said parties, their employees, agents, or representatives pertaining to their respective duties under this Agreement. Such disputes shall be submitted for resolution in accordance with the provider appeal procedures as referenced in the Provider Manual and ACNC

policies and procedures. Neither ACNC nor Provider shall permit a dispute between the parties to disrupt or interfere with the provision of services to Members.

8. TERM; TERMINATION:

- 8.1 The term of this Agreement shall commence as of the Effective Date and, unless earlier terminated in accordance herewith, shall continue for an initial one (1) year term. Thereafter, this Agreement shall automatically renew for successive one (1) year terms unless the Agreement is terminated pursuant to this Section 8 as set forth herein.
- 8.2 Either party may terminate this Agreement at the end of the initial term or at any time thereafter by providing the other party with at least ninety (90) days prior written notice of its intention to terminate this Agreement. The effective date of termination will be on the first of the month following the expiration of the notice period.
- 8.3 Either party may terminate this Agreement for cause due to a material breach by giving ninety (90) days' prior written notice. The notice of termination for cause will not be effective if the breaching party cures the breach within the first sixty (60) days of the ninety (90) day notice period. In the event that the breaching party does not cure the breach within the sixty (60) day period, the effective date of termination will be the first of the month following the expiration of the ninety (90) day notice period.
- 8.4 Termination of this Agreement for any reason, including without limitation the insolvency of ACNC, shall not release Provider from his or her obligations to serve Members when continuation of a Member's treatment is Medically Necessary.
- 8.5 In the event any change in federal or State laws, rules and regulations or the North Carolina Medicaid Program or the Medicare Advantage program would have a material adverse impact on either ACNC or Provider in connection with the performance of this Agreement (the "Mandated Changes") such that the basis for the financial bargain of this Agreement is undermined, then the affected party shall have the right to require the other, by written notice, to enter into negotiations regarding the affected or pertinent terms of this Agreement while still maintaining the original Agreement purposes. If renegotiated, such terms shall become effective no later than thirty (30) days after the parties have reached agreement on the renegotiated terms. The parties agree to make a good faith attempt to renegotiate the Agreement to the extent necessary to comply with any Mandated Changes. If, after good faith renegotiations, the parties fail to reach an agreement satisfactory to both parties within thirty (30) days of the request for renegotiation, the party requesting such renegotiation may terminate this Agreement upon ninety (90) days prior written notice to the other party.
- 8.6 Notwithstanding the above, ACNC may terminate this Agreement immediately in the event any of the following occur:
- (a) If Provider (or, if Provider is a group, any Group Physician) or a person with an ownership or control interest in Provider is expelled, disciplined, barred from participation in, or suspended from receiving payment under any state's Medicaid program, Children's Health Insurance Program (CHIP), the Medicare Program under Section 1128 or 1128A of the Social Security Act or any other federal health care program.

- (b) If Provider (or, if Provider is a group, any Group Physician) is debarred, suspended or otherwise excluded from procurement or non-procurement activities under the Federal Acquisition Regulations.
- (c) If Provider (or, if Provider is a group, any Group Physician) is convicted of any felony or of any crime related to the practice of medicine.
- (d) Upon the loss or suspension of the Provider's professional liability coverage set forth under Section 5 of this Agreement.
- (e) The suspension or revocation of Provider's license or other certification or authorization necessary for Provider to render Primary Care Services and/or Specialty Care Services, as applicable, or upon ACNC's reasonable determination that the health, safety or welfare of any Member may be in jeopardy if this Agreement is not terminated.
- (f) If Provider (or, if Provider is a group, any Group Physician) fails to satisfy any or all of the credentialing requirements of ACNC or fails to cooperate with or abide by the Quality Management Program.
- (g) If Provider (or, if Provider is a group, a Group Physician) breaches a material provision of this Agreement or is engaged in any conduct which would injure the business of ACNC.

8.7 With respect to a Group Physician, if ACNC decides to suspend or terminate the Agreement, ACNC shall give the Group Physician written notice, to the extent required under CMS regulations, of the reasons for the action, including, if relevant, the standards and the profiling data the organization used to evaluate the Group Physician and the numbers and mix of Participating Physicians ACNC needs. Such written notice shall also set forth the Group Physician's right to appeal the action and the process and timing for requesting a hearing.

8.8 Upon termination of this Agreement for any reason, ACNC shall notify affected Members of the termination of Provider (or, if Provider is a group, any Group Physician) in accordance with the notification requirements under **42 C.F.R. §422.111(e)**. Regardless of the reason for termination, Provider shall promptly supply to ACNC all information necessary for the reimbursement of outstanding claims. **42 CFR 434.6(a)(6)**.

9. PROGRAM REQUIREMENTS:

Attached hereto and incorporated herein by reference is **Schedule 9**, setting forth such terms and conditions as are necessary to meet State and Federal statutory and regulatory requirements, and other Agency requirements, of the Program. **Schedule 9** is consecutively sub-numbered as necessary for each Program under which Provider is furnishing services under this Agreement. Provider acknowledges that the specific terms as set forth in **Schedule 9** are subject to amendment in accordance with federal and/or State statutory and regulatory changes to the Program. Such amendment shall not require the consent of the Provider or ACNC and will be effective immediately on the effective date thereof, as set forth in Section 10.3. In the event of a conflict between the terms of this Provider Agreement and the requirements set forth in **Schedule 9**, **Schedule 9** shall control.

10. MISCELLANEOUS:

10.1 It is understood that Provider is an independent contractor and in no way is Provider to be considered an employee, agent, or representative of ACNC. It is further understood that Provider

provides specified services to Members in exchange for an agreed upon fee. This Agreement shall not create, nor be deemed or construed to create any relationship between ACNC and Provider other than that of independent contractors, contracting with each other solely for the purpose of performing this Agreement and each party shall be liable solely for their own activities and neither ACNC nor Provider shall be liable to any third party for the activities of the other party to this Agreement.

- 10.2 This Agreement, being for the purpose of retaining the professional services of Provider, shall not be assigned, subcontracted, or delegated by Provider without the express written consent of ACNC.
- 10.3 No alterations or modifications of the terms of this Agreement shall be valid unless such alterations or modifications are incorporated into the Agreement through a written amendment, signed by both parties hereto, and attached to this Agreement; provided, however, ACNC may amend this Agreement with 30 days' notice to Provider via a(n) ACNC bulletin or other written communication provided in accordance with the notice provisions in Section 10.6, and unless Provider notifies ACNC, as applicable, of any objection, such amendment shall then take effect. Any amendment to this Agreement subject to prior regulatory approval(s) shall be effective once such regulatory approval(s) has been received.

Notwithstanding the foregoing, amendments required because of legislative, regulatory or governmental agency requirements do not require the consent of Provider or ACNC and shall be effective immediately on the effective date thereof. This Agreement remains subject to the approval of the State of North Carolina, and may be amended by ACNC to comply with any requirements of the State of North Carolina. Provider acknowledges that all Agency requirements, as may be amended from time to time, are incorporated to this Agreement.

- 10.4 This Agreement shall be deemed to have been made and shall be construed and interpreted in accordance with the laws of the State of North Carolina.
- 10.5 This Agreement and its exhibits, appendices, schedules, addenda or other attachments constitute the entire understanding and agreement between the parties concerning the subject matter hereof. This Agreement supersedes all prior written or oral agreements or understandings existing between the parties concerning the subject matter hereof including, but not limited to, any such agreement which may have been previously executed between Provider and ACNC or any of its Affiliates relating to the provision of Covered Services under the Program. In the event of a conflict between the terms of this Agreement and the Provider Manual, the terms of the later document shall control.
- 10.6 Written notices to be given hereunder shall be sent by Certified Mail, Return Receipt Requested, or by an overnight delivery service which provides a written receipt evidencing delivery to the address set forth by the party, or by confirmed facsimile followed by written notice through the U.S. postal service. All notices called for hereunder shall be effective upon receipt.

If to Provider: Administrator
1203 Maple Street
Greensboro, NC 27405

With a copy to:

If to AmeriHealth Caritas North Carolina, Inc.:

ATTN:

With a copy to: General Counsel
AmeriHealth Caritas
200 Stevens Drive
Philadelphia, PA 19113

- 10.7 Both parties agree that there shall be no discrimination in the performance of this Agreement against any patient or other person as the result of that individual's race, color, religion, gender, sexual orientation, handicap, age, national origin, source of payment, or any other basis prohibited by law.
- 10.8 The failure of any of the parties to insist upon strict performance of any of the terms of this Agreement shall not be deemed a waiver of any of their respective rights or remedies, and shall not be deemed a waiver of any subsequent breach or default in any of the terms contained in this Agreement.
- 10.9 In the event that any provision under this Agreement is declared null or void, for any reason, the remaining provisions of this Agreement shall remain in full force and effect.
- 10.10 The parties will use reasonable care and due diligence in performing this Agreement. Provider will be solely responsible for the services provided under this Agreement.
- 10.11 All captions contained in this Agreement are solely for the convenience of the parties hereto and shall not be deemed part of the content of this Agreement.
- 10.12 All terms used in this Agreement are deemed to refer to the masculine, feminine, neuter, singular or plural as the content may require.
- 10.13 Non-Discrimination. Provider shall comply with (i) Title VI of the Civil Rights Act of 1964 and the rules, regulations, and order; (ii) the Rehabilitation Act of 1973 and the rules, regulations, and orders thereunder; (iii) the Americans With Disabilities Act of 1990 and the rules, regulations, and orders thereunder; and (iv) any and all applicable laws, rules and regulations prohibiting discriminatory practices. Furthermore, in accordance with Title VI of the Civil Rights Act of 1964 and the rules, regulations and orders thereunder, Provider shall take adequate steps to ensure that Members with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under this Agreement (see 42 U.S.C. 2000d et seq. and 45 C.F.R. Part 80, 2001 as amended).
- 10.14 No Offshore Contracting. No Covered Services under this Agreement may be performed outside of the United States without ACNC's prior written consent. In addition, Provider will not hire any individual to perform any services under this Agreement if that individual is required to have a work visa approved by the U.S. Department of Homeland Security and such individual has not met this requirement.

[SIGNATURES ON FOLLOWING PAGE; REMAINDER OF PAGE INTENTIONALLY BLANK]

IN WITNESS WHEREOF, and intending to be legally bound hereby, the parties hereto, each by its officers duly authorized, hereby affix their hands as of the date written below.

<p>Guilford County Health Department</p> <p>_____</p> <p>Print Name</p> <p>_____</p> <p>Signature</p> <p>_____</p> <p>Title</p> <p>_____</p> <p>Address</p> <p>_____</p> <p>National Provider ID Number</p> <p>_____</p> <p>Medicaid ID Number</p> <p>_____</p> <p>Group Tax ID Number Group Medicare #/PTAN</p> <p>_____</p> <p>Date</p> <p>Assignment of Payment <i>(applicable to Group Physician only):</i> By signing below, Provider hereby assigns and transfers all Provider's right to and interest in compensation payable by ACNC pursuant to this Agreement to the party identified below, and Provider therefore directs ACNC to pay such compensation to said party:</p> <p>_____</p> <p>Provider Signature</p> <p>_____</p> <p>Name of Group</p> <p>_____</p> <p>Address</p> <p>_____</p> <p>Group Tax ID Number Group Medicare #/PTAN</p> <p>Check and initial if Assignment of Payment Not Applicable: <input type="checkbox"/> Provider Initials _____</p>	<p>AmeriHealth Caritas North Carolina, Inc.</p> <p>_____</p> <p>Name</p> <p>_____</p> <p>Signature</p> <p>_____</p> <p>Title</p> <p>_____</p> <p>Date</p> <p>Effective Date of Agreement: _____ [To be completed by AmeriHealth Caritas North Carolina, Inc.]</p>
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APPENDIX A

COVERED SERVICES

Primary Care Services

In Provider's capacity as a Primary Care Provider, Provider shall provide all Primary Care Services to Members who have selected or been assigned to Provider as their Primary Care Provider including the following:

1. All primary ambulatory care visits and routine office procedures;
2. Periodic physical examinations;
3. Routine injections and immunizations, including vaccinations;
4. Arrange for and/or provide inpatient medical care at ACNC participating hospital providers;
5. Referrals, as required, to Specialty Care Providers;
6. Referrals, as required, to ACNC participating providers for lab, radiology and other appropriate services;
7. Provision or arrangement for Primary Care Services twenty-four (24) hours a day, seven (7) days a week; and
8. Exercise primary responsibility for arranging and coordinating the delivery of Medically Necessary health care services to Members.

Specialty Care Services

In Specialty Provider's capacity as a Specialty Care Provider, Provider shall provide all Specialty Care Services to Members including the following:

1. Ambulatory care visits;
2. Arrange for and/or provide inpatient medical care at ACNC participating hospital providers; and
3. Emergency or consultative Specialty Care Services twenty-four (24) hours a day, seven (7) days a week.

APPENDIX B

**PROVIDERS AND OFFICE LOCATIONS
COVERED BY AGREEMENT**

**PRIMARY/SPECIALTY CARE
PROVIDER(S)**

**PRIMARY/SPECIALTY CARE
PROVIDER(S)**

_____(see attached data sheet or roster)_____
Name

Name

Name

Name

Name

Name

Name

Name

Name

Name

PRACTICE LOCATION ADDRESS

PRACTICE LOCATION ADDRESS

Address

Address

City, State, ZIP

City, State, ZIP

Phone Number

Phone Number

APPENDIX C COMPENSATION

Primary Care Provider Compensation

Commencing on the Effective Date, ACNC will compensate Provider for all Primary Care Services rendered by Provider to Members in accordance with the terms of this Agreement at a rate of **100% of the Medicaid Fee Schedule(s)** in effect on the date that Primary Care Services were rendered, less applicable co-insurance and deductibles. Payments will be made in accordance with North Carolina Medicaid payment policies, and with retroactive effective dates as necessary to coincide with the effective dates of changes made by the Agency to its fee schedule. In no event will ACNC's payment exceed Provider's charges.

Specialty Care Provider Compensation

Commencing on the Effective Date, ACNC will compensate Provider for all Specialty Care Services rendered by Provider to Members in accordance with the terms of this Agreement at a rate of **100% of the Medicaid Fee Schedule(s)** in effect on the date that the Specialty Care Services were rendered, less applicable co-insurance and deductibles. Payments will be made in accordance with North Carolina Medicaid payment policies, and with retroactive effective dates as necessary to coincide with the effective dates of changes made by the Agency to its fee schedule. In no event will ACNC's payment exceed Specialty Provider's charges.

Value-Based Program Participation

By participating with ACNC as a participating provider, the Members assigned to the participating provider's associated PCPs will be included in the applicable PerformPlus[®] value-based program(s), as determined by provider type and specialty. The provider-specific program will be implemented pursuant to a written addendum to, and will thereby become incorporated to, this Agreement. For the first year of the program, there will be no downside risk as the program will qualify as meeting state-based requirements. For ongoing participation in a PerformPlus value-based program beyond the first year, the parties agree to negotiate in good faith within one-hundred twenty (120) days of the end of the first year of this Agreement to agree to terms for a value-based model that may include an element of downside risk. In the absence of such an agreement, the PerformPlus value-based program will terminate at the conclusion of the first year of the program.

Compensation for Advanced Medical Homes (AMH)

Tier-Specific Reimbursement Schedule:

AMH Tier 1

- Medical Home Fee: \$1 PMPM – all assigned beneficiaries

AMH Tier 2

- Medical Home Fee: \$2.50 PMPM – non-ABD beneficiaries
- Medical Home Fee: \$5.00 PMPM – members of the ABD eligibility group
- Optional: Value-Based Performance Incentive Payments

AMH Tier 3

- Medical Home Fee: \$2.50 PMPM – non-ABD beneficiaries
- Medical Home Fee: \$5.00 PMPM – members of the ABD eligibility group
- Care Management Fee: TBD
- Value-Based Performance Incentive Payments: See attached Addendum and/or Exhibit TBD

**APPENDIX D
PHYSICIAN PROVIDER**

ACNC AFFILIATES

ACNC Affiliates Covered by Agreement – None.

Schedule 9-1

Federal Requirements – Medicaid and Medicaid Managed Care

(Rev. 7/1/17)

1. No payment will be made to Provider for provider-preventable conditions or health care-acquired conditions. For purposes hereof:
 - a. **Health care-acquired condition** (“HAC”) means a condition occurring in any inpatient hospital setting, identified as a HAC by the Secretary of the U.S. Department of Health and Human Services (“HHS”) under section 1886(d)(4)(D)(iv) of the Social Security Act (the “Act”) for purposes of the Medicare program identified in the State plan as described in section 1886(d)(4)(D)(ii) and (iv) of the Act, other than deep vein thrombosis/pulmonary embolism as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients.
 - b. **Other provider-preventable condition** means a condition occurring in any health care setting that meets the following criteria: (i) is identified in the North Carolina Medicaid plan; (ii) has been found by the North Carolina, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines (iii) has a negative consequence for the Member; (iv) is auditable; and (v) includes, at a minimum, wrong surgical or other invasive procedure performed on a patient, surgical or other invasive procedure performed on the wrong body part, or surgical or other invasive procedure performed on the wrong patient.
 - c. **Provider-preventable condition** (“PPC”) means a condition that meets the definition of “health care-acquired condition” or an “other provider-preventable condition.”

No reduction in payment will be made for a PPC when the condition existed prior to the initiative of treatment for that patient by Provider. Provider shall identify PPCs when submitting claims for payment or, if no claim will be submitted, if Medicaid payment would otherwise be available for the course of treatment in which the PPC occurred, or as otherwise required by the State. **42 CFR §§438.3(g), 434.6(a)(12) and 447.26.**

2. **Physician Incentives.** Provider shall disclose to ACNC annually any Physician Incentive Plan (PIP) or risk arrangements Provider may have with physicians, either within Provider’s group practice or other physicians not associated with Provider’s group practice, even if there is no substantial financial risk between ACNC and the physician or physician group. The term “substantial financial risk” means a financial risk set at greater than twenty-five percent (25%) of potential payments for Covered Services, regardless of the frequency of assessment (i.e., collection) or distribution of payments. The term “potential payments” means simply the maximum anticipated total payments that the physician or physician group could receive if the use or cost of referral services were significantly low. **42 CFR §§438.3(i), 422.208, 422.210.**
3. **Provider Discrimination Prohibited.** ACNC may not, with respect to Provider participation, compensation or indemnification under this Agreement, discriminate against Provider to the extent that the Provider is acting within the scope of his, her or its license or certification under applicable State law, solely on the basis of that license or certification. Without limiting the foregoing, ACNC shall not discriminate against Provider for serving high-risk populations or

specializing in conditions that require costly treatment. Nothing herein shall be construed to: (i) require ACNC to contract with Provider if not necessary to meet the needs of Members; (ii) preclude ACNC from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or (iii) preclude ACNC from establishing measures that are designed to maintain quality of services and control costs and are consistent with ACNC's responsibilities to Members. **42 CFR §§438.12, 438.214(c).**

4. **Member Rights.** Provider shall adhere to all applicable Federal and State laws that pertain to Member rights, and shall take such rights into account when furnishing services to Members. **42 CFR §438.100(a)(2).**
5. **Provider-Member Communications.** Nothing in this Agreement shall be construed to prohibit, restrict or impede Provider's ability to freely and openly discuss with Members, within the Provider's lawful scope of practice, all available treatment options and any information the Member may need in order to decide among all relevant treatment options, including but not limited to the risks, benefits and consequences of treatment or non-treatment, regardless of whether the services may be considered Covered Services in accordance with this Agreement. Further, nothing in this Agreement shall be construed to prohibit, restrict or impede Provider from discussing Medically Necessary care and advising or advocating appropriate medical care with or on behalf of a Member, including: information regarding the nature of treatment options, risks of treatment, alternative treatments or the availability of alternative therapies, consultation or tests that may be self-administered, and the Member's right to participate in decisions regarding his or her care, including the right to refuse treatment and to express preferences about future treatment decisions. **42 CFR §438.102(a).**
6. **Member Hold Harmless.** Provider shall accept the final payment made by ACNC as payment in full for Covered Services provided pursuant to this Agreement. Provider agrees that in no event, including, but not limited to, nonpayment by the Agency to ACNC, nonpayment by ACNC to Provider, the insolvency of ACNC, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, solicit or accept any surety or guarantee of payment, or have any recourse against Members or persons other than ACNC acting on their behalf (including parent(s), guardian, spouse or any other person legally, or potentially legally, responsible person of the Member) for Covered Services listed in this Agreement. This provision shall not prohibit collection of supplemental charges or co-payments on ACNC's behalf made in accordance with terms of an enrollment agreement between ACNC and Members.

Provider further agrees that:

- a. this hold harmless provision shall survive the termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of Members; and that
- b. this hold harmless provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and Members or persons acting on their behalf.

42 CFR §§438.106, 447.15.

7. **Coverage and Payment for Emergency Services.** ACNC shall cover and pay for Emergency Services rendered by Provider and obtained when a Member had an Emergency Medical

Condition, or when a representative of ACNC has instructed the Member to seek Emergency Services. **42 CFR §438.114(c)(1)(ii).**

8. **Timely Access.** Provider shall meet Agency standards for timely access to care and services, taking into account the urgency of the need for services. Provider shall offer hours of operation to Members that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if Provider serves only Medicaid enrollees. Provider services shall be available 24 hours a day, 7 days a week, when medically necessary. Provider shall provide physical access, reasonable accommodations, and accessible equipment for Members with physical or mental disabilities. **42 CFR §438.206(c).**
9. **Excluded Providers.** Pursuant to **42 CFR §438.214(d)**, ACNC may not employ or contract with providers, or have a relationship with a person or entity that is excluded from participation in Federal health care programs under either Section 1128 or 1128A of the Act. ACNC may not knowingly have a Prohibited Relationship (defined hereinafter) with the following: (a) an entity or individual that is debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549; or (b) an individual or entity who is an affiliate, as defined in the Federal Acquisition Regulation at 48 CFR §2.101 of a person described in the **subparagraph 9(a)**. For purposes of this **paragraph 9**, “Prohibited Relationship” includes a subcontractor of ACNC and a network provider or person with an employment, consulting or other arrangement with ACNC for the provision of items or services that are significant and material to ACNC’s obligations under the Agency Contract. Provider shall comply with the disclosure, screening and enrollment requirements of **42 C.F.R. Part 455, Subparts B and E** and, upon reasonable request, provide such information to ACNC in accordance with the requirements specified therein. **42 CFR §§438.608(b), 438.610**

Provider represents and warrants that neither it, nor any of its contractors or employees who will furnish goods or services under the Agreement, directors or officers, or any person with an ownership interest in Provider of five percent (5%) or more, is or ever has been: (i) debarred, suspended or excluded from participation in Medicare, Medicaid, the State Children’s Health Insurance Program (SCHIP) or any other Federal health care program; (ii) convicted of a criminal offense related to the delivery of items or services under the Medicare or Medicaid program; (iii) had any disciplinary action taken against any professional license or certification held in any state or U.S. territory, including disciplinary action, board consent order, suspension, revocation, or voluntary surrender of a license or certification; or (iv) debarred or suspended from participation in procurement or non-procurement activities by any federal agency (collectively, “Sanctioned Persons”). Provider shall screen all employees and contractors who will furnish goods or services under this Agreement to determine whether they have been excluded from participation in any Federal health care program, by searching applicable Federal and State databases (including but not limited to the OIG’s LEIE and the NPDB) upon initial employment or engagement of or contracting with a contractor, employee, director or officer, and on a monthly basis thereafter.

Provider shall immediately notify ACNC upon knowledge by Provider that any of its contractors or employees who furnish goods or services under the Agreement, directors, officers or owners has become a Sanctioned Person, or is under any type of investigation which may result in their becoming a Sanctioned Person. In the event that Subcontractor cannot provide reasonably satisfactory assurance to ACNC that a Sanctioned Person will not receive payment from ACNC under this Agreement, ACNC may immediately terminate this Agreement. ACNC reserves the right to recover all amounts paid by ACNC for items or services furnished by a Sanctioned

Person. Further, and without limiting Provider's indemnification obligations set forth elsewhere in this Agreement, to the extent penalties, fines or sanctions are assessed against ACNC as a result of Provider's having a relationship with a Sanctioned Person, Provider shall be responsible for the immediate payment of such penalties, fines or sanctions. In the event such payment is not made in a timely manner to ACNC, ACNC shall have the right to offset claims payments to Provider by the amount owed by Provider to ACNC.

10. State and Federal Regulator Access. Provider acknowledges that the U.S. Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS), Office of the Inspector General, the Comptroller General, the Agency [**SPECIFY STATE AGENCIES/REPRESENTATIVES**], and their designees may at any time inspect and audit any records or documents of Provider pertinent to this Agreement, including those pertaining to the quality, appropriateness and timeliness of services; and may at any time inspect the premises, physical facilities and equipment where Medicaid-related activities or work is conducted. The right to audit under this paragraph exists for ten (10) years from the final date of the Agency Contract or from the completion of any audit, whichever is later. **42 CFR §§434.6(a)(5), 438.3(h)**.
11. Provider shall safeguard information about Members as required by Part 431, Subpart D of 42 CFR. **42 CFR §434.6(a)(8)**.
12. Any permitted subcontracts entered into by Provider in order to carry out its obligations under this Agreement must be in writing and fulfill the requirements of 42 CFR Part 438 that are appropriate to the service or activity delegated under the subcontract, in accordance with 42 CFR **§438.230**. **42 CFR §§434.6(a)(11), (b), 438.3(k)**.
13. Provider must retain, as applicable, the following information for a period of not less than ten (10) years:
 - a. Member grievance and appeal records in 42 CFR §438.416;
 - b. Base data used to determine capitation rates, in 42 CFR §438.5(c);
 - c. MLR reports in 42 CFR §438.8(k); and
 - d. The data, information and documentation specified in 42 CFR §§438.604 , 438.606, 438.608 and 438.610.**42 CFR §438.3(u)**.
14. Provider shall maintain and share, as appropriate, an enrollee health record in accordance with professional standards. **42 CFR §438.208(b)(5)**.
15. To the extent Provider conducts UM activities on behalf of ACNC, Provider's compensation under this Agreement shall not be structured so as to provide incentives for Provider to deny, limit or discontinue medically necessary services to any Member. **42 CFR §438.210(e)**.
16. Delegation. The following provisions shall apply to the extent any of ACNC's activities or obligations under the Agency Contract are delegated to Provider:

- a. The delegated activities and related reporting responsibilities will be specified in the Agreement or in a separate delegation contract;
- b. Provider agrees to perform the delegated activities and reporting responsibilities in company with ACNC's Agency Contract obligations;
- c. ACNC may impose corrective actions, up to and including revocation of the delegated activities or obligations, in instances where the Agency or ACNC determine that Provider has not performed satisfactorily.
- d. To the extent Provider is delegated responsibilities for coverage of services and payment of claims, Provider shall implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste and abuse that meet the requirements of **42 CFR §438.608(a)**.

Notwithstanding the foregoing, ACNC maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of the Agency Contract. **42 CFR §438.230(b)(c)**.

17. Provider agrees to comply with all applicable Medicaid laws, regulations (including applicable sub-regulatory guidance) and Agency Contract provisions. Provider agrees that:

- a. The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate and inspect any books, records, contracts, computer or other electronic system of Provider, or of any subcontractors, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Agency Contract.
- b. Provider will make available, for purposes of an audit, evaluation or inspection under subparagraph 17(a), its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to ACNC's Members.
- c. The right to audit under subparagraph 17(a) will exist through ten (10) years from the final date of the Agency Contract or from the date of completion of any audit, whichever is later.
- d. If the State, CMS or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the state, CMS or the HHS Inspector General may inspect, evaluate and audit Provider at any time.

42 CFR §438.230(c)(2), (3)

18. ACNC may terminate this Agreement immediately upon notification from the Agency that Provider cannot be enrolled in the State Medicaid program, or if Provider has not enrolled in the State Medicaid Program within 120 days of the effective date of this Agreement. **42 CFR §438.602(b)(2)**.

Schedule 9-2

State of North Carolina Requirements – Medicaid and Medicaid Managed Care

Unless defined in this **Schedule 9-2** or elsewhere in the Agreement, all capitalized terms used herein shall have their respective meanings given to them in the Agency Contract between the State of North Carolina Department of Health and Human Services (Agency) and AmeriHealth Caritas North Carolina (Plan) dated as of **February 4, 2019** (the Agency Contract).

The provisions set forth herein are intended to set forth the minimum requirements for provider contracts as required by the Agency in that certain **Request for Proposal #: 30-190029-DHB Prepaid Health Plan Services** (the “RFP”). Citations herein are to Section VII.G of the RFP (“Required Standard Provisions for PHP and Provider Contracts”) unless otherwise specified. This Agreement, including this **Schedule 9-2**, is subject to Agency review and approval, and may be amended by the Plan as necessary to comply with Agency requirements, in accordance with Section V.D.2 of the RFP.

1. **Agreement Term.** Notwithstanding anything in this Agreement to the contrary, the term of this Agreement shall not exceed the term of the Agency Contract. (**RFP Section VII.G.1.c**)
2. **Termination.** Without limiting the termination provisions set forth in Section 8 of the Agreement, Plan may immediately terminate this Agreement upon a confirmed finding of fraud, waste, or abuse by the Agency or the North Carolina Department of Justice Medicaid Investigations Division. (**RFP Section VII.G.1.d**)
3. **Survival.** In addition to the indemnification and hold harmless provisions in the Agreement that shall survive its termination, the following provisions shall apply in the event of Plan’s insolvency:
 - a. Plan and Provider shall develop a mutually agreed plan to transition administrative duties and records as necessary;
 - b. Provider shall not be relieved of its obligation to serve Members when continuation of a Member’s treatment is Medically Necessary. Without limiting the foregoing, inpatient care shall be continued until the Member is ready for discharge.

(RFP Section VII.G.1.e)

4. **Credentialing.** Provider shall at all times maintain licensure, accreditation, and credentials sufficient to meet Plan’s network participation requirements as outlined in Plan’s credentialing and re-credentialing policies and procedures; and Provider shall promptly notify Plan of changes in the status of any information relating to Provider’s professional credentials. Without limiting the foregoing:
 - a. Provider shall at all times be enrolled in the North Carolina Medicaid program, in accordance with 42 CFR 455.410. Failure to enroll or maintain enrollment constitutes grounds for immediate termination of this Agreement by Plan.
 - b. Provider shall re-enroll in the North Carolina Medicaid program no less frequently than every five (5) years during the Provider Credentialing Transition Period. For purposes hereof, as set forth in Section V.D.2 of the RFP, “Provider Credentialing Transition Period” is that period of time before the Agency’s Provider Data Management/Credential

Verification Organization (PDM/CVO) has achieved full implementation. Once the PDM/CVO has been fully implemented, Provider shall re-enroll in North Carolina Medicaid no less frequently than every three (3) years, except as otherwise permitted by the Agency.

(RFP Section VII.G.1.f)

5. **Liability Insurance.** Provider's obligation to maintain professional liability coverage is set forth in the Agreement. Provider shall notify Plan of subsequent changes in status of professional liability insurance on a timely basis. **(RFP Section VII.G.1.g)**
6. **Member Billing.** Provider shall not bill any Member for Covered Services, except for specified co-insurance, copayments and applicable deductibles. This restriction shall not prohibit Provider from agreeing with a Member to continue non-Covered Services at the Member's own expense, as long as Provider has notified the Member in advance that the Plan may not cover or continue to cover the non-Covered Services. **(RFP Section VII.G.1.h)**
7. **Provider Accessibility.** Provider shall arrange for call coverage or other back-up to provider service in accordance with Plan's standards for provider accessibility as set forth in the Provider Manual. **(RFP Section VII.G.1.i)**
8. **Eligibility Verification.** Provider is responsible for verifying Member eligibility, prior to rendering health care services, by using the mechanism provided by Plan. **(RFP Section VII.G.1.j)**
9. **Medical Records.** As required by 42 CFR 438.208(b)(5), Provider shall maintain and share, as appropriate, a health record for each Member who receives care or services from Provider in accordance with professional standards. Without limiting the foregoing, Provider shall: (a) maintain confidentiality of Member medical records and personal health information and other health records as required by law; (b) maintain adequate medical and other health records according to industry and Plan standards; and (c) make copies of such records available to Plan and the Agency in conjunction with its regulation of Plan. The records shall be made available and furnished immediately upon request in either paper or electronic form, at no cost to the requesting party. **(RFP Section VII.G.1.k)**
10. **Member Appeals and Grievances.** Provider shall cooperate with Plan in regard to Member appeals and grievance procedures. **(RFP Section VII.G.1.l)**
11. **Provider Payment.** Nothing in this Agreement shall be construed as providing for an automatic increase in payment rates to Provider, and any provision in this Agreement to the contrary shall be void. **(RFP Section VII.G.1.m)**
12. **Data to Provider.** Plan shall furnish Provider with such data and information as may be necessary for Provider to fulfill its obligations to Plan under this Agreement. Such data and information shall include, but is not necessarily limited to: (a) performance feedback reports or information if compensation is related to efficiency criteria; (b) information on benefit exclusions, administrative and utilization management requirements, credential verification programs, quality assessment programs, and provider sanction policies; and (c) notification of changes in these requirements. Plan may provide such information through its Provider Manual and periodic updates thereto. **(RFP Section VII.G.1.n)**
13. **Utilization Management.** Provider shall comply with Plan's utilization management programs, quality management programs, and provider sanctions programs; provided that none of these

programs shall override the professional or ethical responsibility of the Provider, or interfere with Provider's ability to provide information or assistance to its patients. (**RFP Section VII.G.1.o**)

14. **Provider Directory**. Plan shall include Provider's name (and Provider's group name, if applicable), in the Plan's Provider Directory distributed to Members. Provider authorizes Plan to publish Provider's name and relevant practice information in the Plan Provider Directory. (**RFP Section VII.G.1.p**)
15. **Dispute Resolution**. Plan and Provider shall follow the provider dispute process as set forth in the Agreement, the details of which are included in the Provider Manual and Plan policies and procedures made available to Provider. Plan's provider dispute process shall comply with the Agency's guidelines on Provider Grievance and Appeals as found in Section V.D.5 of the RFP "Provider Grievances and Appeals." (**RFP Section VII.G.1.q**) Provider shall exhaust Plan's internal appeal process before seeking other legal or administrative remedies under state or federal law. (**RFP Section V.D.2.c.xi**)
16. **Assignment**. Provider's duties and obligations under the Agreement shall not be assigned, delegated or transferred without the prior written consent of Plan. Plan shall notify Provider, in writing, of any duties or obligations that are to be delegated or transferred, before the delegation or transfer, in the event Plan consents to an assignment by Provider. (**RFP Section VII.G.1.r**)
17. **Government Funds**. The funds used by Plan to make payments to Provider under this Agreement are government funds. (**RFP Section VII.G.1.s**)
18. **Interpreting and Translation Services**.
 - a. Provider must provide qualified sign language interpreters if closed captioning is not the appropriate auxiliary aid for a Member.
 - b. Provider must ensure Provider's staff are trained to appropriately communicate with patients with various types of hearing loss.
 - c. Provider shall report to Plan, in a format and frequency to be determined by Plan, whether hearing loss accommodations are needed and provided, and the type of accommodation provided.

(RFP Section VII.G.1.t)

19. **Perinatal Care Providers**. To the extent Provider furnishes perinatal care, the following shall apply, pursuant to the Agency's Pregnancy Management Program Policy as set forth in Section VII, Attachment M-3 of the RFP:
 - a. Provider shall complete the Pregnancy Management Program (PMP) standardized risk-screening tool (as determined by the Agency) at each initial visit.
 - b. Provider shall allow Plan or Plan's designated vendor access to Member medical records for auditing purposes to measure performance on specific quality indicators.
 - c. Provider commits to maintaining or lowering the rate of elective deliveries prior to thirty-nine (39) weeks gestation.
 - d. Provider commits to decreasing the cesarean section rate among nulliparous women.

- e. Provider shall 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.
- f. Provider shall complete a high-risk screening of each pregnant Member in the Pregnancy Management Program and integrate the plan of care with local pregnancy care management. When Provider refers a high-risk pregnancy to Plan, Plan is responsible for arranging intake of the Member into the statewide Care Management for High Risk Pregnant Women program, and shall inform Provider when the Member has entered to program.
- g. Provider commits to decreasing the primary cesarean delivery rate if the rate is over the Agency's designated cesarean rate. [Note: the Agency will set the rate annually, which will be at or below twenty percent (20%).]
- h. Provider shall ensure that comprehensive post-partum visits occur within fifty-six (56) days of delivery.
- i. Provider shall send all screening information and applicable medical record information for Members in the Care Management of High-Risk Pregnancies to the applicable Prepaid Health Plans (PHPs) and the Local Health Departments (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 (1) business day of the Provider completing the screening.

Without limiting the foregoing, if Provider is an obstetrician, Provider agrees to comply with the Agency's Pregnancy Management Program. (**RFP Section VII.G.1.u**)

20. Advanced Medical Homes. To the extent Provider is an Advanced Medical Home (AMH), as defined in the RFP, Provider agrees to comply with the Agency's Advanced Medical Home Program. Without limiting the foregoing, Provider shall:
- a. Accept Members and be listed as a primary care provider in the Plan's Member-facing materials for the purpose of providing care to Members and managing their health care needs;
 - b. Provide Primary Care and Patient Care Coordination services to each Member, in accordance with Plan policies;
 - c. Provide or arrange for Primary Care coverage for services, consultation or referral, and treatment for emergency medical conditions, twenty-four (24) hours per day, seven (7) days per week. Automatic referral to the hospital emergency department for services does not satisfy this requirement;
 - d. Provide direct patient care a minimum of thirty (30) office hours per week;
 - e. Provide preventive services, in accordance with *Section VII. Attachment M. Table 1: Required Preventive Services* of the RFP;
 - f. Maintain a unified patient medical record for each Member following the Plan's medical record documentation guidelines;

- g. Promptly arrange referrals for medically necessary health care services that are not provided directly and document referrals for specialty care in the medical record;
- h. Transfer the Member's medical record to the receiving provider upon the change of primary care provider at the request of the new primary care provider or Plan (if applicable) and as authorized by the Member within thirty (30) days of the date of the request, free of charge;
- i. Authorize care for the Member or provide care for the Member based on the standards of appointment availability as defined by the Plan's network adequacy standards;
- j. Refer for a second opinion as requested by the Member, based on Agency guidelines and Plan standards;
- k. Review and use Member utilization and cost reports provided by the Plan for the purpose of AMH level utilization management and advise the Plan of errors, omissions, or discrepancies if they are discovered; and
- l. Review and use the monthly enrollment report provided by the Plan for the purpose of participating in Plan or practice-based population health or care management activities.

In addition, if Provider is a Tier 3 AMH, the requirements set forth in the Agency's Advanced Medical Home Policy at Section VII, Attachment M-2 of the RFP, as may be amended from time to time by the Agency, shall apply.

(RFP Section VII.G.1.v)

21. Local Health Departments. To the extent Provider is a LHD carrying out care management for high-risk pregnancy and for at-risk children, Provider shall comply with the Agency's Care Management for High-Risk Pregnancy Policy (at Section VII, Attachment M-4 of the RFP) and Care Management for At-Risk Children Policy (at Section VII, Attachment M-5 of the RFP). The care management requirements set forth in these Agency Policies (as may be amended by the Agency from time to time) are hereby incorporated to this Agreement by reference. **(RFP Section VII.G.1.w)**

22. Chapter 58 (Insurance) Requirements. Pursuant to Section 5.(6).g. of Session Law 2015-245, as amended by Section 6.(b) of Session Law 2018-49 pertaining to Chapter 58 protections, the following provisions shall apply:

- a. Coverage Determinations. As required by G.S. 58-3-200(c), if Plan or its authorized representative determines that services, supplies or other items are Covered Services, including any utilization management determination made by Plan, Plan 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 Plan's determination, unless the determination was based on a material misrepresentation about the Member's health condition that was knowingly made by the Member or Provider.
- b. Prompt Pay. Plan and Provider shall each be bound by the relevant provisions of the North Carolina prompt pay statute codified at G.S. 58-3-225, as in effect from time to time (the "Prompt Pay Statute"). Without limiting the applicability of the entirety of the Prompt Pay Statute, Provider shall submit all claims to Plan for processing and payments within one-hundred-eighty (180) calendar days from the date of covered service or

discharge (whichever is later). However, Provider's failure to submit a claim within this time will not invalidate or reduce any claim if it was not reasonably possible for Provider to submit the claim within that time. In such case, the claim should be submitted as promptly 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):

1. Plan shall, within eighteen (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.
2. Plan shall pay or deny a medical Clean Claim at the lesser of thirty (30) calendar days of receipt of the claim or the first scheduled provider reimbursement cycle following adjudication.
3. A pended medical claim shall be paid or denied within thirty (30) calendar days of receipt of the requested additional information.

ii. For Pharmacy claims:

1. Plan shall, within fourteen (14) calendar days of receiving a pharmacy claim, pay or deny a pharmacy Clean Claim or notify Provider that more information is needed to process the claim.
2. A pended pharmacy claim shall be paid or denied within thirty (30) calendar days of receipt of the requested additional information.

- iii. Plan shall re-process medical and pharmacy claims in a timely and accurate manner as described in this section (including interest and penalties if applicable). If the requested additional information on a pended medical or pharmacy claim is not submitted within ninety (90) days of the notice requesting the required additional information, Plan shall deny the claim, per G.S. 58-3-225(d).
- iv. If Plan fails to pay a Clean Claim in full pursuant to this section, Plan shall pay Provider interest and penalty. Late payments will bear interest at the annual rate of eighteen percent (18%) beginning on the date following the day on which the claim should have been paid or was underpaid.
- v. Failure to pay a Clean Claim within thirty (30) days of receipt will result in Plan paying the Provider a penalty equal to one percent (1%) of the total amount of the claim per day, beginning on the date following the date on which the claim should have been paid or was underpaid.
- vi. Plan shall pay the interest and penalty from subsections G.S. 58-3-225(e) and G.S. 58-3-225(f) as provided in those subsections, and shall not require Provider to request the interest or the penalty.
- vii. Plan shall provide no less than thirty (30) days' advance written notice of its intent to recover an overpayment from Provider, which recovery may be made through an offset against future claim payments. Plan may not recover overpayments more than two (2) years after the date of the original claim

payment unless Plan has reasonable belief of fraud or other intentional misconduct by Provider or its agents. Provider may not seek recovery of underpayments from Plan more than two (2) years after the date of the original claim adjudication.

(RFP Section VII.G.3.h)

- c. **Fee Schedule; Claim Submission.** In accordance with G.S. 58-3-227, Plan shall make available its schedule of fees associated with the top thirty (30) services or procedures most commonly billed by the class of providers to which Provider belongs (e.g., primary care provider, specialist, hospital, etc.). Plan's claim submission and reimbursement policies are set forth in the Provider Manual, which shall be made available on Plan's website. Plan shall furnish advance notice to Provider of any changes to the information required to be furnished to Provider under G.S. 58-3-227 in accordance with the notice requirements set forth in the Agreement, but in no event less than thirty (30) days prior to the change.
- d. **Notice Contact.** In accordance with G.S. 58-3-275, Plan and Provider shall indicate notice contacts as provided in the applicable section of the Agreement. Notwithstanding anything therein to the contrary, the means for providing notice shall be one of the following, calculated as: (i) five business days following the date the notice is placed, first-class postage prepaid, in the U.S. 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.
- e. **Contract Amendments.** Notwithstanding anything in the Agreement to the contrary, in accordance with G.S. 58-50-280, if Plan initiates an amendment to the Agreement, Plan shall send any proposed contract amendment to Provider's notice contact with at least sixty (60) days' advance notice. The proposed amendment shall be dated, labeled "Amendment," signed by Plan, and include an effective date for the proposed amendment. Provider's failure to object in writing to the proposed amendment within the 60-day notice period shall constitute Provider's assent to and acceptance of the proposed amendment. If Provider objects to the proposed amendment, then the proposed amendment shall not be effective with respect to Provider, and Plan shall be entitled to terminate the Agreement with sixty (60) days' advance written notice to Provider. Nothing herein shall be deemed to prohibit Plan and Provider from amending the Agreement on mutually agreed terms within mutually agreed time periods. Further, Plan's right to terminate the Agreement as provided in this section shall not be deemed to be an affirmative obligation; and Plan and Provider may negotiate a mutually acceptable alternative to the proposed amendment in order to prevent termination of the Agreement.
- f. **Policies and Procedures.** In accordance with G.S. 58-50-285, Plan shall provide a copy of its policies and procedures, in the form of the Provider Manual, to Provider, prior to execution of this Agreement or any amendment to the Agreement, and at least annually. Plan may meet this requirement by posting its Provider Manual on its website. In the event of a conflict between Plan policies and procedures and this Agreement, the language of this Agreement shall prevail.

(RFP Section VII.G.1.x)

- 23. **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 this Agreement and the Plan's managed care contract with the North Carolina Department of Health and Human Services (NC DHHS), 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 this contract, or any violation of Plan's contract with NC DHHS could result in liability for money damages, and/or civil or criminal penalties and sanctions under state and/or federal law. (**RFP Section VII.G.3.a**)

24. **Hold Member Harmless.** Provider agrees to hold the Member harmless for charges for any Covered Service. Provider agrees not to bill a Member for Medically Necessary services covered by Plan so long as the Member is eligible for coverage. (**RFP Section VII.G.3.b**)

25. **Liability.** Provider understands and agrees that the NC DHHS does not assume liability for the actions of, or judgments rendered against, Plan, its employees, agents or subcontractors. Further, Provider understands and agrees that there is no right of subrogation, contribution, or indemnification against NC DHHS for any duty owed to Provider by Plan or any judgment rendered against Plan. (**RFP Section VII.G.3.c**)

26. **Non-discrimination; Equitable Treatment of Members.** Provider agrees to render services to Members with the same degree of care and skills as customarily provided to Provider's patients who are not Members, according to generally accepted standards of medical practice. Provider and Plan agree that Members and non-Members should be treated equitably. Provider agrees not to discriminate against Members on the basis of race, color, national origin, age, sex, gender or disability. (**RFP Section VII.G.3.d**)

27. **Department Authority Related to the Medicaid Program.** Provider agrees and understands that in the State of North Carolina, the Department of Health and Human Services 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. (**RFP Section VII.G.3.e**)

28. **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 the Agreement and any records, books, documents, and papers that relate to the Agreement and/or the Provider's performance of its responsibilities under this Agreement for purposes of examination, audit, investigation, contract administration, the making of copies, excerpts or transcripts, or any other purpose NC DHHS deems necessary for contract enforcement or to perform its regulatory functions:

- a. The United States Department of Health and Human Services or its designee;
- b. The Comptroller of the United States or its designee;
- c. NC DHHS, its Medicaid managed care program personnel, or its designee;
- d. The Office of Inspector General;
- e. North Carolina Department of Justice Medicaid Investigations Division;
- f. Any independent verification and validation contractor, audit firm or quality assurance contractor acting on behalf of NC DHHS;

- g. The North Carolina Office of State Auditor, or its designee;
- h. A State or federal law enforcement agency; and
- i. Any other state or federal entity identified by NC DHHS, or any other entity engaged by NC DHHS.

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

Nothing in this section 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.

(RFP Section VII.G.3.f)

29. **Provider Ownership Disclosure.** Provider agrees to disclose the required information, at the time of application, and/or upon request, in accordance with 42 C.F.R. § 455 Subpart B, related to ownership and control, business transactions, and criminal conviction for offenses against Medicare, Medicaid, CHIP and/or other federal health care programs. See 42 C.F.R. § 455, Parts 101 through 106 for definitions, percentage calculations, and requirements for disclosure of ownership, business transactions, and information on persons convicted of crimes related to any federal health care programs.

Provider agrees to notify, in writing, Plan and NC DHHS of any criminal conviction within twenty (20) days of the date of the conviction.

(RFP Section VII.G.3.g)

30. Providers who are primary care providers shall perform EPSDT screenings for Members less than twenty-one (21) years of age, in accordance with Section V.C.2 of the RFP, "Early and Periodic Screening, Diagnosis and Treatment (EPSDT)." **(RFP Section V.D.2.c.xiii)**
31. Hospital Providers shall notify Plan when a Member in a high-level clinical setting is being discharged. **(RFP Section V.D.2.c.xiv)**
32. Nothing in this Agreement shall be construed to violate G.S. 58-50-295. Accordingly, no provision of this Agreement shall do any of the following:
- a. Prohibit, or grant Plan an option to prohibit, Provider from contracting with another health insurance carrier to provide health care services at a rate that is equal to or lower than the payment specified in this Agreement;
 - b. Require Provider to accept a lower payment rate from Plan in the event Provider agrees to provide health care services to any other health insurance carrier at a rate that is equal to or lower than the payment specified in this Agreement;
 - c. Require, or grant Plan an option to require, termination or renegotiation of this Agreement in the event Provider agrees to provide health care services to any other health insurance carrier at a rate that is equal to or lower than the payment specified in this Agreement;

- d. Require, or grant Plan an option to require, Provider to disclose, directly or indirectly, Provider's contractual rates with another health insurance carrier;
- e. Require, or grant Plan an option to require, the non-negotiated adjustment by Plan of the Provider's contractual rate to equal the lowest rate Provider has agreed to charge to any other health insurance carrier; or
- f. Require, or grant Plan an option to require, Provider to charge another health insurance carrier a rate that is equal to or more than the reimbursement rate specified in this Agreement.

(RFP Section V.D.2.c.xvi)

33. Provider shall not submit claim or encounter data for Covered Services directly to NC DHHS.

(RFP Section V.D.2.c.xviii)

Schedule 9-3

Medicaid Managed Care Addendum for Indian Health Care Providers

1. Purpose of Addendum: Supersession.

The purpose of this Medicaid Managed Care Addendum for Indian Health Care Providers (IHCPs) is to apply special terms and conditions necessitated by federal law and regulations to the network IHCPs agreement by and between (herein "Managed Care Plan") and (herein "Indian Health Care Provider (IHCP)"). To the extent that any provision of the Managed Care Plan's network IHCP agreement or any other addendum thereto is inconsistent with any provision of this Addendum, the provisions of this Addendum shall supersede all such other provisions.

2. Definitions.

For purposes of this Addendum, the following terms and definitions shall apply:

(a) **"Indian"** means any individual defined at 25 U.S.C. §§ 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 C.F.R. § 136.12. This means the individual is a Member of a federally recognized Indian tribe or resides in an urban center and meets one or more of the following criteria:

- i. Is a Member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the state in which they reside, or who is a descendant, in the first or second degree, of any such Member;
- ii. Is an Eskimo or Aleut or other Alaska Native;
- iii. Is considered by the Secretary of the Interior to be an Indian for any purpose;
- iv. Is determined to be an Indian under regulations issued by the Secretary.

The term "Indian" also includes an individual who is considered by the Secretary of the Interior to be an Indian for any purpose or is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.

(b) **"Indian Health Care Provider (IHCP)"** means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in Section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

(c) **"Managed Care Plan"** includes a Managed Care Organization (MCO), Prepaid Ambulatory Health Plan (PAHP), Prepaid Inpatient Health Plan (PIHP), Primary Care Case Management (PCCM) or Primary Case Managed Care Entity (PCCM entity) as those terms are used and defined in 42 C.F.R. 438.2, and any subcontractor or instrumentality of such entities that is engaged in the operation of a Medicaid managed care contract.

(d) **"Indian Health Service or IHS"** means the agency of that name within the U.S. Department of Health and Human Services established by the IHCA Section 601, 25 U.S.C. § 1661.

(e) **"Indian tribe"** has the meaning given in the IHCA Section 4(14), 25 U.S.C. § 1603(14).

(f) **"Tribal health program"** has the meaning given in the IHCA Section 4(25), 25 U.S.C. § 1603(25).

(g) **"Tribal organization"** has the meaning given in the IHCA Section 4(26), 25 U.S.C. § 1603(26).

(h) **"Urban Indian organization"** has the meaning given in the IHCA Section 4(29), 25 U.S.C. § 1603(29).

3. **Description of IHCP.**

The IHCP identified in Section 1 of this Addendum is (check the appropriate box):

IHS.

An Indian tribe that operates a health program under a contract or compact to carry out programs, services, functions, and activities (or portions thereof) of the IHS pursuant to the ISDEAA, 25 U.S.C. §450 et seq.

A tribal organization that operates a health program under a contract or compact to carry out programs, services, functions, and activities (or portions thereof) of the IHS pursuant to the ISDEAA, 25 U.S.C. § 450 et seq.

A tribe or tribal organization that operates a health program with funding provided in whole or part pursuant to 25 U.S.C. § 47 (commonly known as the Buy Indian Act).

An urban Indian organization that operates a health program with funds in whole or part provided by IHS under a grant or contract awarded pursuant to Title V of the IHCA.

4. **Cost-Sharing Exemption for Indians; No Reduction in Payments.**

The Managed Care Plan shall not impose any enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing, or similar charge shall be imposed against an Indian who is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization or Urban Indian Organization or through referral under contract health services.

Payments due to the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or a health care IHCP through referral under contract health services for the furnishing of an item or service to an Indian who is eligible for assistance under the Medicaid program may not be reduced by the amount of any enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing, or similar charge. Section 1916(j) of the Social Security Act, and 42 C.F.R. 447.53 and §457.535.

5. **Enrollee Option to Select the IHCP as Primary Health Care IHCP.**

The Managed Care Plan shall allow any Indian otherwise eligible to receive services from an IHCP to choose the IHCP as the Indian's primary health care provider if the IHCP has the capacity to provide primary care services to such Indian, and any referral from such IHCP shall be deemed to satisfy any coordination of care or referral requirement of the Managed Care Plan. Section 1932(h)(1) of the Social Security Act, 42 C.F.R. § 438.14(b)(3) and 457.1209.

6. **Agreement to Pay IHCP.**

The Managed Care Plan shall pay the IHCP for covered Medicaid managed care services in accordance with the requirements set out in Section 1932(h) of the Social Security Act and 42 C.F.R. §§ 438.14 and 457.1209.

7. **Persons Eligible for Items and Services from IHCP.**

(a) Nothing in this agreement shall be construed to in any way change, reduce, expand, or alter the eligibility requirements for services through the IHCP's programs, as determined by federal law including the IHCA, 25 U.S.C. § 1601, et seq. and/or 42 C.F.R. Part 136.

(b) No term or condition of the Managed Care Plan's network IHCP agreement or any addendum thereto shall be construed to require the IHCP to serve individuals who are ineligible for services from the IHCP. The Managed Care Plan acknowledges that pursuant to 45 C.F.R. § 80.3(d), an individual shall not be deemed subjected to discrimination by reason of his/her exclusion from benefits limited by federal law to individuals eligible for services from the IHCP. IHCP acknowledges that the nondiscrimination provisions of federal law may apply.

8. **Applicability of Federal Laws not Generally Applicable to other Providers.**

Certain federal laws and regulations apply to IHCPs, but not other providers. IHCPs cannot be required to violate those laws and regulations as a result of serving MCO enrollees. Applicable provisions may include, but are not limited to, those laws cited in within this Contract.

9. **Non-Taxable Entity.**

To the extent the IHCP is a non-taxable entity, the IHCP shall not be required by a Managed Care Plan to collect or remit any federal, state, or local tax.

10. **Insurance and Indemnification.**

(a) **Indian Health Service.** The IHS shall not be required to obtain or maintain insurance (including professional liability insurance), provide indemnification, or guarantee that the managed care plan will be held harmless from liability. This is because the IHS is covered by the Federal Tort Claims Act (FTCA), which means that the United States consents to be sued in place of federal employees for any damages to property or for personal injury or death caused by the negligence or wrongful act or omission of federal employees acting within the scope of their employment. Nothing in the managed care plan network provider agreement (including any addendum) shall be interpreted to authorize or obligate any IHS employee to perform any act outside the scope of his/her employment.

(b) **Indian Tribes and Tribal Organizations.** A provider which is an Indian tribe, a tribal organization, or employee of a tribe or tribal organization (including contractors) shall not be required to obtain or maintain insurance (including professional liability insurance), provide indemnification, or guarantee that the managed Care Plan will be held harmless from liability to the extent that the provider is covered by the FTCA. Nothing in the Managed Care Plan network provider agreement (including any addendum) shall be interpreted to authorize or obligate such Provider, any employee of such provider, or any personal services contractor to operate outside of the scope of FTCA coverage.

(c) **Urban Indian Organizations.** A provider which is an urban Indian organization shall not be required to obtain or maintain insurance (including professional liability insurance), provide indemnification, or guarantee that the managed care plan will be held harmless from liability to the extent the provider is covered by the FTCA. Nothing in the Managed Care Plan network provider agreement or any addendum thereto shall be interpreted to authorize or obligate such Provider or any employee of such Provider to operate outside of the scope of the FTCA.

11. **Licensure and Accreditation.**

Pursuant to 25 U.S.C. §§ 1621t and 1647a, the managed care organization shall not apply any requirement that any entity operated by the IHS, an Indian tribe, tribal organization or urban Indian organization be licensed or recognized under the state or local law where the entity is located to furnish health care services, if the entity meets all the applicable standards for such licensure or recognition. In addition, the managed care organization shall not require the licensure of a health professional employed by such an entity under the state or local law where the entity is located, if the professional is licensed in another state.

12. **Dispute Resolution.**

In the event of any dispute arising under the Managed Care Plan's network IHCP agreement or any addendum thereto, the parties agree to meet and confer in good faith to resolve any such disputes. Notwithstanding any provision in the Managed Care Plan's network agreement, the IHCP shall not be required to submit any disputes between the parties to binding arbitration.

13. **Governing Law.**

The Managed Care Plan's network IHCP agreement and all addenda thereto shall be governed and construed in accordance with federal law of the United States. In the event of a conflict between such agreement and all addenda thereto and federal law, federal law shall prevail.

Nothing in the Managed Care Plan's network IHCP agreement or any addendum thereto shall subject an Indian tribe, tribal organization, or urban Indian organization to state law to any greater extent than state law is already applicable.

14. **Medical Quality Assurance Requirements.**

To the extent the Managed Care Plan imposes any medical quality assurance requirements on its network IHCPs, any such requirements applicable to the IHCP shall be subject to Section 805 of the IHCA, 25 U.S.C. § 1675.

15. **Claims Format.**
The Managed Care Plan shall process claims from the IHCP in accordance with Section 206(h) of the IHCIA, 25 U.S.C. § 1621e(h), which does not permit an issuer to deny a claim submitted by a IHCP based on the format in which submitted if the format used complies with that required for submission of claims under Title XVIII of the Social Security Act or recognized under Section 1175 of such Act.
16. **Payment of Claims.**
The Managed Care Plan shall pay claims from the IHCP in accordance Section 1932(h)(2) of the Act and 42 C.F.R. §§ 438.14(c)(2) and 457.1209, and shall pay at either the rate provided under the State plan in a Fee-for-Service payment methodology, or the applicable encounter rate published annually in the Federal Register by the Indian Health Service, whichever is higher.
17. **Hours and Days of Service.**
The hours and days of service of the IHCP shall be established by the IHCP. The IHCP agrees that it will consider input from the Managed Care Plan as to its hours and days of service. At the request of the Managed Care Plan, such IHCP shall provide written notification of its hours and days of service.
18. **Purchase/Referred Care Requirements.**
The Provider may make referrals to in-network providers and such referrals shall be deemed to meet any coordination of care and referral obligations of the Managed Care Plan. The Provider shall comply with coordination of care and referral obligations of the Managed Care Plan issuer except only in specific circumstances in which such obligations would conflict with requirements applicable to Purchased/Referred Care at 42 C.F.R. Part 136. The Provider will notify the Managed Care Plan issuer when such circumstances occur.
19. **Sovereign Immunity.**
Nothing in the Managed Care Plan’s network IHCP agreement or in any addendum thereto shall constitute a waiver of federal or tribal sovereign immunity.
20. **Endorsement.**
IHS or IHCP names and positions may not be used to suggest official endorsement or preferential treatment of the managed care plan.

APPROVALS

For the Managed Care Plan:

For the IHCP:

_____ _____
Date *Date*

(a) The IHS as an IHCP:

- (1) Anti-Deficiency Act, 31 U.S.C. § 1341;
- (2) ISDEAA, 25 U.S.C. § 450 et seq.;
- (3) Federal Tort Claims Act (“FTCA”), 28 U.S.C. §§ 2671-2680;
- (4) Federal Medical Care Recovery Act, 42 U.S.C. §§ 2651-2653;
- (5) Federal Privacy Act of 1974 (“Privacy Act”), 5 U.S.C. § 552a, 45 C.F.R. Part 5b;
- (6) IHCIA, 25 U.S.C. § 1601 et seq.

(b) An Indian tribe or a Tribal organization that is an IHCP:

- (1) ISDEAA, 25 U.S.C. § 450 et seq.;
- (2) IHCIA, 25 U.S.C. § 1601 et seq.;

- (3) FTCA, 28 U.S.C. §§ 2671-2680;
- (4) Federal Medical Care Recovery Act, 42 U.S.C. §§ 2651-2653;
- (5) Privacy Act, 5 U.S.C. § 552a, 45 C.F.R. Part 5b;

(c) An urban Indian organization that is an IHCP:

- (1) IHCIA, 25 U.S.C. § 1601 et seq.
- (2) Privacy Act, 5 U.S.C. § 552a, 45 C.F.R. Part 5b;