September 21, 2015

RE: Louisiana Medicaid and CHIP Program Regulatory Requirements Appendix (Provider)

Dear OptumRx Participating Pharmacy:

Thank you for participating in the OptumRx Pharmacy Networks.

Please find enclosed the final version of the Louisiana Medicaid and CHIP Program regulatory requirements appendix ("Appendix"), which will be contained in the next OptumRx 2015 Pharmacy Manual updated release.

As applicable, this Appendix applies with respect to the provision of Covered Prescription Services that Pharmacy provides directly to Members through Client’s benefit plans under the State of Louisiana’s Bayou Health and related programs as governed by the State’s designated regulatory agencies.

In accordance with your particular pharmacy Agreement with OptumRx, we are hereby providing this Notice Amendment that updates the Pharmacy Manual to comply with new Louisiana requirements that became effective September 15, 2015.

Please do not hesitate to contact us should you have any questions. We value your participation in the applicable Louisiana Government Programs pharmacy network.

Sincerely,

Jeff Grosklags
Chief Financial Officer
OptumRx

OptumRx Phone Number

Pharmacy Contract Department via email at pharmacycontracts@optum.com or at (800) 613-3591, option 7, Monday through Friday from 8:00 a.m. to 4:00 p.m. PT.

Thank you for your continued support. Please distribute immediately.
LOUISIANA MEDICAID AND CHIP PROGRAM
REGULATORY REQUIREMENTS APPENDIX

PROVIDER

THIS LOUISIANA MEDICAID AND CHIP PROGRAM REGULATORY REQUIREMENTS APPENDIX (this “Appendix”) supplements and is made part of the provider agreement (the “Agreement”) between UnitedHealthcare Insurance Company or one of its Affiliates and the party named in the Agreement (“Provider”).

SECTION 1
APPLICABILITY

The requirements of this Appendix apply to Medicaid and CHIP benefit plans sponsored, issued or administered by UnitedHealthcare of Louisiana, Inc. (referred to in this Appendix as “United”) under the State of Louisiana’s Bayou Health and related programs (collectively, the “State Program”), as governed by the State’s designated regulatory agencies. In the event of a conflict between this Appendix and other appendices or any provision of the Agreement, the provisions of this Appendix shall control except with regard to benefit plans outside the scope of this Appendix or unless otherwise required by law. In the event United is required to amend or supplement this Appendix as required or requested by the State, Provider agrees that United shall be permitted to unilaterally initiate such additions, deletions or modifications.

SECTION 2
DEFINITIONS

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

2.1 Affiliate: Those entities controlling, controlled by, or under common control with UnitedHealthcare Insurance Company. UnitedHealthcare of Louisiana, Inc. is an Affiliate.

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

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

2.4 Department or DHH: The Louisiana Department of Health and Hospitals.
2.5 **Provider:** An appropriately licensed and/or certified hospital, ancillary provider, physician group, individual physician or other health care provider who has entered into an Agreement.

2.6 **State:** The State of Louisiana or its designated regulatory agencies.

2.7 **State Contract:** United’s contract(s) with DHH for the purpose of providing and paying for Covered Services to Covered Persons enrolled in the State Program.

2.8 **State Program:** The State of Louisiana’s Bayou Health and related programs where United provides services to Louisiana residents through a contract with the State. For purposes of this Appendix, “State Program” may refer to the State agency(ies) responsible for administering the State Program.

**SECTION 3**

**PROVIDER REQUIREMENTS**

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

3.1 **Covered Services; Definitions Related to Coverage.** Provider shall follow the State Contract’s requirements for the provision of Covered Services. A description of the package of benefits offered by DHH under the State Program is available on the DHH website at [http://www.makingmedicaidbetter.com/](http://www.makingmedicaidbetter.com/). Provider’s decisions affecting the delivery of acute or chronic care services to Covered Persons shall be based on the individual’s medical needs and in accordance with the following definitions:

(a) **Emergency Medical Condition:** A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: (1) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

(b) **Emergency Services:** Covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish these services under 42 CFR Part 438.114(a) and § 1932(b)(2) of the Social Security Act of 1935 (42 U.S.C. § 1396u-2) and that are needed to screen, evaluate, and stabilize an Emergency Medical Condition. Emergency Services also include services defined as such under Section 1867(e) of the Social Security Act (“anti-dumping provisions”). There are no prior authorization requirements for Emergency Services.
(c) **Medically Necessary or Medical Necessity:** Those health care services that are in accordance with generally accepted, evidence-based medical standards or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care. In order to be considered Medically Necessary, services must be: (1) deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain or have resulted or will result in a handicap, physical deformity or malfunction; and (2) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease. Any such services must be clinically appropriate, individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the recipient requires at that specific point in time. Services that are experimental, non-FDA approved, investigational, or cosmetic are specifically excluded from Medicaid coverage and will be deemed “not medically necessary.”

3.2 **Accessibility Standards.** Provider shall provide for timely access to Covered Person appointments in accordance with the appointment availability requirements established under the State Contract and shall offer hours of operation that are no less than the hours of operation offered to commercial or non-Medicaid/CHIP members or comparable to Medicaid fee-for-service beneficiaries if Provider serves only Medicaid beneficiaries.

3.3 **Indemnification.** At all times during the Agreement, Provider shall indemnify, defend, protect, and hold harmless DHH and any of its officers, agents, and employees from:

(a) Any claims, losses, or suits relating to activities undertaken by Provider pursuant to the Agreement or pursuant to the State Contract;

(b) Any claims for damages or losses arising from services rendered by any contractor, person, or firm performing or supplying services, materials, or supplies for Provider in connection with performance of the Agreement or in connection with performance of the State Contract;

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

(d) Any claims for damages or losses resulting to any person or firm injured or damaged by Provider, its agents, officers, employees, or contractors, by Provider’s publication, translation, reproduction, delivery, performance, use, or disposition of any data processed under the Agreement in a manner not authorized by the Agreement, the State Contract, or by federal or State regulations or statutes;
(e) Any failure of Provider, its agents, officers, employees, or contractors, to observe federal or State laws, including but not limited to labor laws and minimum wage laws;

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

(g) Any injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against DHH or its agents, officers or employees, through the intentional conduct, negligence or omission of Provider, its agents, officers, employees or contractors.

In the event that, due to circumstances not reasonably within the control of United, Provider, or DHH (i.e., a major disaster, epidemic, complete or substantial destruction of facilities, war, riot or civil insurrection), neither United, Provider, or DHH will have any liability or obligation on account of reasonable delay in the provision or the arrangement of Covered Services; provided, however, that so long as the State Contract remains in full force and effect, United shall be liable for authorizing services required in accordance with the State Contract.

3.4 Hold Harmless. Except for any applicable cost-sharing requirements under the State Contract, Provider shall look solely to United for payment of Covered Services provided to Covered Persons pursuant to the Agreement and the State Contract and hold the State, the U.S. Department of Health and Human Services and Covered Persons harmless in the event that United cannot or will not pay for such Covered Services. In accordance with 42 CFR Part 447.15, as may be amended from time to time, the Covered Person is not liable to Provider for any services for which United is liable and as specified under the State’s relevant health insurance or managed care statutes, rules or administrative agency guidance. Provider shall not require any copayment or cost sharing for Covered Services provided under the Agreement unless expressly permitted under the State Contract. Provider shall also be prohibited from charging Covered Persons for missed appointments if such practice is prohibited under the State Contractor applicable law. Neither the State, the Department nor Covered Persons shall be in any manner liable for the debts and obligations of United and under no circumstances shall United, or any providers used to deliver services covered under the terms of the State Contract, charge Covered Persons for Covered Services. Provider shall accept the final payment made by United as payment-in-full for core benefits and services provided and shall not solicit or accept any surety or guarantee of payment from DHH or the Covered Persons(s). Covered Person shall include the patient, parent(s), guardian, spouse or any other legally or potentially legally, responsible person of the member being served.

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

3.5 **Record Keeping.**

(a) **Maintenance.** In conformity with requirements under State and federal law and the State Contract, Provider shall maintain an adequate record keeping system for recording services, service providers, charges, dates and all other commonly required information elements for services rendered to Covered Persons pursuant to the Agreement, including but not limited to such records as are necessary for evaluation of the quality, appropriateness, and timeliness of services performed under the Agreement. All records originated or prepared in connection with Provider’s performance of its obligations under the Agreement, including but not limited to working papers related to the preparation of fiscal reports, medical records, progress notes, charges, journals, ledgers, and electronic media, shall be retained and safeguarded by Provider in accordance with the terms and conditions of the State Contract.

(b) **Medical Records.** Provider shall retain medical records at the site where medical services are provided. Each Covered Person’s medical 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. Provider shall maintain the confidentiality of medical records in accordance with 42 CFR 438.224 and 45 CFR Parts 160 and 164, subparts A and E, as may be amended from time to time. Covered Persons and their representatives shall be given access to and can request copies of the Covered Person’s medical records, to the extent and in the manner provided by Louisiana Revised Statutes § 40:1299.96 and 45 CFR Part 164.3524, as amended, and subject to reasonable charges. In addition, DHH or its designee shall have immediate and complete access to all records pertaining to the health care services provided to Covered Persons. Medical record requirements are further defined in the State Contract.

(c) **Retention.** Provider shall retain all administrative, financial and programmatic records, supporting documents, statistical records, medical records, other records of Covered Persons relating to the delivery of care or services under the State Contract, and such other records as required by DHH (whether paper or electronic) for the later of: (i) six (6) years from the expiration date of the State Contract, including any extension(s) thereof; or (ii) for Covered Person records, for six (6) years after the last payment was made for services provided to the Covered Person (an exception to this requirement includes records pertaining to once in a lifetime events, including but not limited to appendectomy and amputations, etc., which must be retained indefinitely and may not be destroyed); or (iii) such other period as required by law. Notwithstanding the foregoing, if the records are under review or audit or related to any matter in litigation, such records shall be retained until completion of the audit, review or litigation and resolution of all issues which arise from it or until the end of the six (6) year period, whichever is later. If Provider stores records on microfilm or microfiche or other electronic means, Provider
shall produce, at its expense, legible hard copy records within twenty-one (21) calendar days upon the request of State or federal authorities.

The above record retention requirements pertain to the retention of records for Medicaid purposes only; other State or federal rules may require longer retention periods. Current State law (LRS 40:1299.96) requires physicians to retain their records for at least six (6) years, commencing from the last date of treatment.

(d) **Records Upon Termination.** United and Provider recognize that in the event of termination of the State Contract for any of the reasons described therein, Provider shall immediately make available to United, in a usable form, any and all records, whether medical or financial, related to Provider’s activities undertaken pursuant to the Agreement and the State Contract so that United can immediately make available the same to DHH or its designated representative. The provision of such records shall be at no expense to the Department.

3.6 **Privacy; Confidentiality.** Provider understands that the use and disclosure of information concerning Covered Persons is restricted to purposes directly connected with the administration of the State Program and shall maintain the confidentiality of Covered Person's information and records as required by the State Contract and in federal and State law including, but not limited to, all applicable privacy, security and Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Public Law 104-191, and associated implementing regulations, including but not limited to 45 CFR Parts 160, 162, 164, as applicable and as may be amended from time to time, and shall safeguard information about Covered Persons in accordance with applicable federal and State privacy laws and rules including but not limited to 42 CFR §438.224, 42 CFR Part 2, and 42 CFR Part 431, Subpart F; 42 CFR Part 434 and 42 CFR 438.6 (if applicable), as may be amended from time to time.

Provider further acknowledges that, in some cases, it will have access to information on individuals with whom Provider has no treatment or other relationship. In such cases Provider will abide by all requirements under HIPAA and ensure that the confidentiality of such information is fully maintained.

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

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

3.7 Compliance with Laws, State Contract and DHH-Issued Guides. Provider shall comply with all requirements for Health Plan subcontractors set forth in the State Contract and DHH-issued guides, as well as with all applicable federal and State laws, rules, regulations and guidelines applicable to the provision of services under the State Program. The State Contract and DHH-issued guides shall be furnished to Provider upon request. Provider may also access these documents on the DHH website at http://www.makingmedicaidbetter.com. United also shall furnish Provider (either directly or through a web portal) with United’s provider manual and member handbook.

3.8 Physician Incentive Plans. In the event Provider participates in a physician incentive plan ("PIP") under the Agreement, Provider agrees that such PIPs must comply with 42 CFR 438.6(h), 42 CFR 422.208, and 42 CFR 422.210, as may be amended from time to time. Neither United nor Provider may make a specific payment directly or indirectly under a PIP to a physician or physician group as an inducement to reduce or limit Medically Necessary services furnished to an individual Covered Person. PIPs must not contain provisions that provide incentives, monetary or otherwise, for the withholding of Medically Necessary care.

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

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

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

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

3.11 Excluded Individuals. By signing the Agreement, Provider certifies to the best of Provider’s knowledge and belief that neither it nor any of its principals, nor any providers, subcontractors or consultants with whom Provider contracts for items or services that are significant and material to Provider’s obligations under the Agreement, is:

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

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

Provider is obligated to screen its employees and contractors initially and on an ongoing monthly basis to determine whether any of them have been excluded from participation in Medicare, Medicaid, SCHIP, or any Federal Health Care Programs (as defined in Section 1128B(f) of the Social Security Act). Provider shall not employ or contract with an individual or entity that has been excluded. Provider shall immediately report to United any exclusion information discovered. Provider acknowledges and agrees that civil monetary penalties may be imposed against Provider if he or she employs or enters into contracts with excluded individuals or entities to provide items or Covered Services. Provider can search the HHS-OIG website, at no cost, by the names of any individuals or entities through the following databases: LEIE at http://www.oig.hhs.gov/fraud/exclusions.asp; the Health Integrity and Protection Data Bank
United will exclude from its network any provider who has been excluded from the Medicare or Medicaid program in any state.

3.12 Cultural Competency. Provider shall deliver services in a culturally competent manner to all Covered Persons, including those with limited English proficiency and diverse cultural and ethnic backgrounds. In accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.) (2001, as amended) and its implementing regulation at 45 C.F.R. Part 80 (2001, as amended), Provider shall take adequate steps to ensure that persons 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 the Agreement.

3.13 Marketing Materials. As required under State or federal law or the State Contract, any marketing materials developed and/or distributed by Provider as related to the State Program and performance of the Agreement must be submitted to United to submit to the Department for prior approval. In addition, Provider shall comply with the State Contract’s requirements related to marketing communications.

3.14 Fraud, Abuse, and Waste Prevention. Provider shall cooperate fully with United’s policies and procedures designed to protect program integrity and prevent and detect potential or suspected fraud, abuse and waste in the administration and delivery of services under the State Contract. Provider also shall cooperate with and assist DHH and any other State or federal agency charged with the duty of preventing, identifying, investigating, sanctioning or prosecuting suspected fraud, abuse or waste in state and/or federal health care programs. This shall include reporting to United any cases of suspected Medicaid fraud or abuse by Covered Persons, other providers in United’s network, employees, or subcontractors of Provider. Provider shall report such suspected fraud or abuse to United in writing as soon as practical after discovering suspected incidents.

In accordance with United’s policies and the Deficit Reduction Act of 2005 (DRA) Provider shall have written policies for its employees, contractors or agents that: (a) provide detailed information about the federal False Claims Act (established under sections 3729 through 3733 of title 31, United States Code); (b) cite administrative remedies for false claims and statements (established under chapter 38 of title 31, United States Code) and whistleblower protections under federal and state laws; (c) reference state laws pertaining to civil or criminal penalties for false claims and statements; and (d) with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in federal health care programs (as defined in section 1128B(f)), include as part of such written policies, detailed provisions regarding Provider’s policies and procedures for detecting and preventing fraud, waste, and abuse. Provider agrees to train its staff on the aforesaid policies and procedures.

3.15 Outstanding Claim Information. In the event of termination of the Agreement, Provider shall promptly supply to United or its designee all information necessary for the reimbursement of any outstanding Medicaid claims.

3.16 Acknowledgement Regarding Funds. Provider acknowledges and agrees that funds paid to Provider under the Agreement are derived from State and federal funds pursuant to the State
Contract. Provider further acknowledges and agrees that acceptance of such funds acts as acceptance of the authority of the Louisiana Legislative Auditor, or any successor agency, to conduct an investigation in connection with those funds. Provider agrees to cooperate fully with the Louisiana Legislative Auditor or its successor conducting the audit or investigation, including providing all records requested.

3.17 Electronic Health Records. Provider shall participate in DHH’s endeavor to move toward meaningful use of Electronic Health Records. An “Electronic Health Record” is a computer-based record containing health care information.

3.18 Government Inspection, Audit and Evaluation

(a) By State and Federal Agencies. Provider acknowledges and agrees that DHH, the U.S. Department of Health and Human Services (HHS), CMS, the Office of Inspector General, the Comptroller General, the State Legislative Auditor’s Office, the Louisiana Attorney General’s Office, any other State or federal entity identified by the Department, and/or designees of any of the above, shall have the right to evaluate through audit, inspection or other means, whether announced or unannounced, any records pertinent to the State Contract, including those pertaining to the quality, appropriateness and timeliness of services provided pursuant to the State Contract and the timeliness and accuracy of encounter data and practitioner claims submitted to United. Provider shall cooperate with such evaluations and, upon request by United or any of the entities listed above, assist in such reviews. In addition, the above entities and/or their designees, at any time and as often as they may deem necessary during the State Contract period and for a period of six (6) years thereafter (including any extensions to the State Contract), shall have the right to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services provided under the terms of the State Contract and any other applicable rules. There shall be no restrictions on the right of the State or federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness or timeliness of services provided pursuant to the State Contract and the reasonableness of their costs.

(b) By DHH. In addition to the above, Provider shall make its records available for fiscal audit, medical audit, medical review, utilization review, and other periodic monitoring upon request of an authorized representative of DHH.

3.19 Quality Assessment/Utilization Management Review. Provider shall adhere to the State Program’s Quality Assessment and Performance Improvement (QAPI) program requirements, as outlined in the State Contract and the Quality Companion Guide, which are incorporated herein by reference and shall be furnished to Provider upon request. Provider shall cooperate with United’s QAPI and utilization management (UM) programs, which adhere to all DHH QAPI and UM program requirements. Provider agrees to participate and cooperate in any internal or external quality assessment review, utilization management, or grievance procedures established by United and/or the Department or its designee, whether such review or procedures are announced or unannounced.
3.20 **Insurance.** Before commencing the provision of services under the Agreement, Provider shall obtain, and maintain throughout the term of the Agreement: (a) Workers’ Compensation Insurance for all of Provider’s employees that provide services under the Agreement; and (b) all necessary liability and malpractice insurance coverage as is necessary to adequately protect Covered Persons and United under the Agreement. Provider shall furnish United with written verification of the existence of such coverage prior to execution of the Agreement. DHH and United shall be exempt from and in no way liable for any sums of money that may represent a deductible in any insurance policy maintained by Provider; the payment of such a deductible shall be the sole responsibility of Provider.

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

3.22 **Ownership and Control Information.** Provider shall comply with and submit to United disclosure of information in accordance with the requirements specified in 42 CFR Part 455, Subpart B (42 CFR §§ 455.100 – 106), as may be amended from time to time.

3.23 **Subcontracts; Assignment.** Provider shall not enter into any subsequent agreements or subcontracts for any of the work or services contemplated under the Agreement, nor assign any of its duties or responsibilities under the Agreement, without the prior written consent of United.

3.24 **Term; Service Standards.** All services provided under the Agreement must be in accordance with the Louisiana Medicaid State Plan. Provider shall provide such services to Covered Persons through the last day of the month that the Agreement is in effect. Provider acknowledges and agrees that all final Medicaid benefit determinations are within the sole and exclusive authority of the Department or its designee.

3.25 **Refusal Not Permitted.** Provider may not refuse to provide Medically Necessary or core preventative benefits and services specified under the State Contract to Covered Persons for non-medical reasons (except those services allowable under federal law for religious or moral objections). Notwithstanding this Section, Provider shall not be required to accept or continue treatment of a Covered Person with whom Provider feels Provider cannot establish and/or maintain a professional relationship.
3.26 **Data and Reports.** Provider shall submit to United all reports and clinical information which United or DHH may require for reporting purposes pursuant to the State Contract, including but not limited to encounter data, HEDIS, AHRQ and EPSDT data and reports, where applicable. Provider shall utilize DHH’s Louisiana Immunization Network for Kids Statewide (LINKS) web-based immunization reporting system for the reporting of all adult and child vaccinations. As applicable, if United has entered into alternative reimbursement arrangements with Provider (with prior approval by the Department), Provider is required to submit all encounter data to the same standards of completeness and accuracy as required for proper adjudication of fee-for-service claims by United. NOTE: United is not allowed to enter into alternative reimbursement arrangements with FQHCs or RHCs.

3.27 **Payment Submission.** Provider will promptly submit complete and accurate claims information required for payment and/or DHH-required reports. Provider shall submit claims for payment in accordance with the time frames specified in the Agreement, but in all cases no later than 365 days from the date of service.

If Provider discovers an error or a conflict with a previously adjudicated encounter claim, Subcontractor and/or Health Plan shall be required to adjust or void the encounter claim within fourteen (14) calendar days of notification by DHH or if circumstances exist that prevent Subcontractor and/or Health Plan from meeting this time frame a specified date shall be approved by DHH.

When Subcontractor has entered into an alternative reimbursement arrangement with Provider, all encounter data must comply with the same standards of completeness and accuracy as required for proper adjudication of claims by the Subcontractor.

3.28 **Notice of Adverse Actions.** Provider shall give United immediate notification in writing by certified mail of any litigation, investigation, complaint, claim or transaction that may reasonably be considered to have a material impact on Provider’s ability to perform its obligations under the Agreement.

3.29 **State Custody.** Provider is not permitted to encourage or suggest, in any way, that Covered Persons be placed in State custody in order to receive medical or specialized behavioral health services covered by DHH.

3.30 **Services.** Provider shall perform those services set forth in the Agreement. Provider represents that the services to be provided by Provider pursuant to the Agreement are within the scope of Provider’s practice.

3.31 **Conflict of Interest.** Provider represents and covenants that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of its services under the Agreement. Provider further covenants that, in the performance of the Agreement, it shall not employ any person having any such known interests.

3.32 **Appeals and Grievances.** Provider shall comply with United’s process for Covered Person appeals and grievances, including emergency appeals, as set forth in the provider manual. This shall include but not be limited to the following:
(a) Assisting a Covered Person by providing appeal forms and contact information, including the appropriate address, telephone number and/or fax number for submitting appeals for United and/or State level review; and

(b) Displaying notices in public areas of Provider’s facility(ies) of a Covered Person’s right to appeal adverse actions affecting Covered Services in accordance with DHH’s rules and regulations, subsequent amendments, and any and all consent decrees and court orders. United shall ensure that Provider has a correct and adequate supply of such public notices.

3.33 Penalties; Sanctions. Provider acknowledges and agrees that DHH has the right to direct United to impose financial consequences against Provider, as appropriate, for Provider’s failure to comply with contractual and/or credentialing requirements, including but not limited to failure or refusal to respond to United’s request for information, including credentialing information, or a request to provide medical records.

3.34 Primary Care Provider (“PCP”) Linkages. If Provider is a PCP, Provider stipulates by signing the Agreement that Provider’s total number of Medicaid/CHIP members for the State Program will not exceed 2,500 lives per full-time physician or 1,000 lives per mid-level practitioner or physician extender up to a cap of 2,500 lives. Prior to executing the Agreement, Provider and United shall specify the number of linkages United may link to Provider.

3.35 Birth Registration. As applicable, Provider must register all births through LEERS (Louisiana Electronic Event Registration System) administered by the DHH/Vital Records Registry. Hospital Providers must notify United and DHH of the birth of a newborn when the mother is a member of United, complete the web-based DHH Request for Medicaid ID Number, including indicating that the mother is a member of United, and submit the form electronically to DHH.

3.36 Laboratory Services. If Provider performs laboratory services, Provider must meet all applicable State and federal requirements, including but not limited to 42 CFR Sections 493.1 and 493.3, as may be amended from time to time. As applicable, if Provider performs any laboratory tests on human specimens for the purpose of diagnosis and/or treatment, Provider agrees to acquire and maintain the appropriate CLIA certification or waiver for the type of laboratory testing performed. Provider further agrees to provide a copy of the certification if requested by United. A State authorized license or permit that meets the CLIA requirements may be substituted for the CLIA certificate pursuant to State law. Medicare and Medicaid programs require the applicable CLIA certification or waiver for the type of services performed as a condition of payment. Provider must include the appropriate CLIA certificate or waiver number on claims submitted for payment for laboratory services.

3.37 Compliance with Medicaid Laws and Regulations. Provider agrees to abide by the Medicaid laws, regulations and program instructions to the extent applicable to Provider in Provider’s performance of the Agreement. Provider understands that payment of a claim by United or the State is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited to, federal requirements on fraud, waste and abuse, disclosure, debarment and exclusion screening), and is
conditioned on the Provider’s compliance with all applicable conditions of participation in Medicaid. Provider understands and agrees that each claim the Provider submits to United constitutes a certification that the Provider has complied with all applicable Medicaid laws, regulations and program instructions in connection with such claims and the services provided therein. Provider’s payment of a claim may be temporarily suspended if the State or United provides notice that a credible allegation of fraud exists and there is a pending investigation.

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

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

3.40 **Continuity of Care.** Provider shall cooperate with United and provide Covered Persons with continuity of treatment, including coordination of care to the extent required under law and according to the terms of the Agreement, in the event Provider’s participation with United terminates during the course of a Covered Person’s treatment by Provider, except in the case of adverse reasons on the part of Provider.

3.41 **Advance Directives.** Provider shall comply with the advance directives requirements for hospitals, nursing facilities, providers of home and health care and personal care services, hospices, and HMOs as specified in 42 CFR Part 49, subpart I, and 42 CFR § 417.436(d).

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

3.43 **Non-Discrimination.** In performance of obligations under the Agreement and in employment practices, Provider shall not exclude, deny benefits or otherwise subject to discrimination, any persons on the grounds of handicap, and/or disability, age, race, color, religion, sex, national origin, or any other classifications protected under federal or state laws. In addition, Provider shall upon request show proof of such nondiscrimination compliance and shall post notices of nondiscrimination in conspicuous places available to all employees and applicants.

3.44 **Homeland Security Considerations.** In accordance with the State Contract, Provider shall perform all obligations under the Agreement within the boundaries of the United States. In addition, Provider will not hire any individual to perform any services under the 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.

3.45 **Antitrust.** Provider assigns to the State of Louisiana any and all rights or claims it currently has or may acquire under any state or federal antitrust laws and that are attributable to any product units purchased or reimbursed through any State Program or payment mechanism, including but not limited to product units purchased or reimbursed under the state’s managed
Medicaid program, currently known as Bayou Health. For purposes of this assignment clause, “Provider” shall include any direct or indirect owner to whom the right or claim to be assigned actually belongs, including any and all parents, branches, departments or subsidiaries.

SECTION 4
UNITED REQUIREMENTS

4.1 Payment. The method and amount of compensation paid to Provider for performance of services under the Agreement and the name and address of the official payee to whom payment shall be made shall be as set forth in the Agreement. United and Provider acknowledge and agree that the Agreement shall not contain terms for reimbursement at rates less than the published Medicaid fee-for-service rate in effect on the date of service unless a Provider-initiated request has been submitted to and approved by DHH. United shall not propose to Provider reimbursement rates that are less than the published Medicaid fee-for-service rate. United shall pay ninety percent (90%) of all clean claims of each provider type, within fifteen (15) business days of the date receipt. United shall pay ninety-nine (99%) of all clean claims of each provider type, within thirty (30) calendar days of the date of receipt. The date of receipt is the date the United receives the claim, as indicated by its date stamp on the claim. The date of payment is the date of the check or other form of payment. United and Provider may, by mutual agreement, establish an alternative payment schedule. Any alternative schedule must be stipulated in the Agreement. As applicable, United shall reimburse FQHCs/RHCs the PPS rate in effect on the date of service for each encounter. If a third party liability exists, payment of claims shall be determined in accordance with federal and/or State third party liability law and the terms of the State Contract. Unless United otherwise requests assistance from Provider, United will be responsible for third party collections in accordance with the terms of the State Contract.

4.2 Provider Discrimination Prohibition. In accordance with 42 CFR 438.12 and 438.214(c), United shall not discriminate with respect to the participation, reimbursement or indemnification of a provider who is acting within the scope of such provider’s license or certification under applicable State law, solely on the basis of such license or certification. Further, United shall not discriminate with respect to the participation, reimbursement or indemnification of any provider who serves high-risk Covered Persons or specializes in conditions requiring costly treatments. This provision shall not be construed as prohibiting United from limiting a provider’s participation to the extent necessary to meet the needs of Covered Persons. This provision also is not intended and shall not interfere with measures established by United that are designed to maintain quality of care practice standards and control costs.

4.3 Provider-Covered Person Communication. United shall not prohibit or otherwise restrict Provider, when acting within the lawful scope of practice, from advising or advocating on behalf of a Covered Person who is Provider’s patient for any the following:

(a) The Covered Person’s health status, medical care, or treatment options for the Covered Person’s condition or disease, including any alternative treatment that may be self-administered, regardless of whether benefits for such care or treatment are provided under the State Contract;
(b) Any information the Covered Person needs in order to decide among all relevant treatment options;

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

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

4.4 No Restrictions on Other Contracts. Nothing in the Agreement or this Appendix shall be construed to prohibit or restrict Provider from entering into a contract with another Health Plan or other managed care entity.

4.5 United Compliance with Laws, State Contract and DHH-Issued Guides. United shall comply with all requirements for Health Plans set forth in the State Contract and DHH-issued guides, as well as with all applicable federal and State laws, regulations and guidelines applicable to the provision of services under the State Program.

4.6 No Contracting with Exclusive Providers. United shall not have a contract arrangement with any service provider in which the provider represents or agrees that it will not contract with another Health Plan or in which the United represents or agrees that United will not contract with another provider.

4.7 No Suggestion of Exclusivity. United shall not advertise or otherwise hold itself out as having an exclusive relationship with any service provider.

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

SECTION 5
OTHER REQUIREMENTS

5.1 State Contract. All tasks performed under the Agreement shall be performed in accordance with the requirements of the State Contract, the applicable provisions of which are incorporated into the Agreement by reference. Nothing in the Agreement relieves United of its responsibility under the State Contract. If any requirement or provision of the Agreement or this Appendix is determined by DHH to conflict with the State Contract, the terms of the State Contract shall control and the terms of the Agreement or this Appendix in conflict with those of the State Contract shall be null and void. All other provisions of the Agreement and this Appendix shall remain in full force and effect.
5.2 **Ongoing Monitoring.** As required under the State Contract, United shall perform ongoing monitoring (announced or unannounced) of services rendered by Provider under the Agreement and shall perform periodic formal reviews of Provider according to a schedule established by the State, consistent with industry standards or State managed care organization laws and regulations or DHH requirements under the State Contract. As a result of such monitoring activities, United shall identify to Provider any deficiencies or areas for improvement mandated under the State Contract and Provider and United shall take appropriate corrective action. Provider shall comply with any corrective action plan initiated by United and/or required by the Department. In addition, Provider shall monitor and report the quality of services delivered under the Agreement and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which United and Provider practice and/or the performance standards established by DHH in the State Contract and DHH-issued guides.

5.3 **Entire Agreement; Incorporation of Applicable Law; Modifications.** The Agreement and its appendices, including this Appendix, contain all the terms and conditions agreed upon by the parties. The Agreement incorporates by reference all applicable federal and State laws or regulations and revisions of such laws or regulations shall automatically be incorporated into the Agreement as they become effective. In the event that revisions to any applicable federal or State law change the terms of the Agreement so as to materially affect either United or Provider, the parties agree to negotiate such further amendments as may be necessary to correct any inequities. Except as otherwise provided herein or in the Agreement, no modification or change of any provision of the Agreement or this Appendix may be made unless such modification is incorporated and attached as a written amendment to the Agreement or Appendix and signed by United and Provider. Additional procedures and criteria for any alteration, variation, modification, waiver, extension or early termination of the Agreement shall be as set forth in the Agreement.

5.4 **Independent Contractor Relationship.** Provider expressly agrees that it is acting in an independent capacity in the performance of the Agreement and not as an officer or agent, express or implied, and/or employee of DHH or the State. Provider further expressly agrees that neither the Agreement nor this Appendix shall be construed as a partnership or joint venture between Provider and DHH or the State.

5.5 **Utilization Management Compensation.** In accordance with 42 CFR Part 438.210(e), the compensation paid to United or any individuals that conduct utilization management activities on behalf of United shall not be structured so as to provide incentives for the individual or United to deny, limit, or discontinue Medically Necessary services to any Covered Person.

5.6 **Delegated Activities.** Any activities delegated to Provider by United shall be set forth in the Agreement or such other written delegation agreement or addendum between the parties. The Agreement or delegation agreement/addendum shall specify the activities and reporting responsibilities delegated to Provider and provide for revoking delegation or imposing other sanctions if Provider’s performance is inadequate. Prior to delegating any activities to Provider under the State Contract, United will evaluate Provider’s ability to perform such activities.
5.7 **State Approval.** United and Provider acknowledge that DHH shall have the right to review and approve all subcontracts entered into for the provision of Covered Services under the State Contract. United will submit and obtain prior approval from DHH of all model subcontracts, including material modifications to previously approved subcontracts, for all care management providers. United and Provider acknowledge and agree that, prior to execution, the Agreement is subject to the review and approval of DHH, as are any amendments or subsequent material modifications to the Agreement.

5.8 **Dispute Resolution.** Provider and United agree to resolve any disputes that may arise between them in accordance with the terms of the Agreement. The parties agree that no dispute will disrupt or interfere with the provision of services to Covered Persons, including continuity of care should the Agreement be terminated.

5.9 **Health Care-Acquired/Preventable Conditions.** United and Provider acknowledge and agree that United is prohibited from making payments to Provider for the provision of medical assistance for health care-acquired conditions and other provider-preventable conditions as may be identified by DHH.

5.10 **No Barriers to Access Covered Services.** Neither United nor Provider shall enter into any agreement that would implement barriers to access to Covered Services. United shall monitor Provider’s compliance with this requirement and will implement a corrective action plan within thirty (30) days if Provider’s compliance is determined to be inadequate. Failure to comply with this requirement will be considered a breach of the Agreement.