TENNCARE PROGRAM
REGULATORY REQUIREMENTS APPENDIX
(Division of TennCare Required Language - Provider Agreements)

DOWNSTREAM PROVIDER

THIS TENNCARE 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 State of Tennessee Medicaid Program benefit plans sponsored, issued or administered by **UnitedHealthcare Plan of the River Valley, Inc.** and Affiliates (referred to in this Appendix as "United") under the TennCare program ("TennCare") as governed by the State's designated regulatory agencies. Effective January 1, 2021, the requirements of this Appendix (unless otherwise specified below) shall also apply to CoverKids. 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 through an amendment to the Provider's Agreement.

SECTION 2
DEFINITIONS

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

2.1 **Abuse:** Provider practices that are inconsistent with sound fiscal, business or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program (see 42 CFR 455.2).

2.2 **Affiliate:** Those entities controlling, controlled by, or under common control with UnitedHealthcare Insurance Company. For purposes of this Appendix and Agreement, such Affiliates may be referred to as UnitedHealthcare Plan of the River Valley, Inc., UPRV, River Valley Plan and UnitedHealthcare Community Plan.

2.3 **Division of TennCare:** The division of the Tennessee Department of Finance and Administration (the single state Medicaid agency) that administers TennCare. For the purposes of the State Contract, the Agreement and this Appendix, Division of TennCare shall mean the State of Tennessee and its representatives.

2.4 **Care Coordinator:** The individual who has primary responsibility for performance of care coordination activities for a TennCare Covered Person receiving Long-Term Services and Supports as specified in this Appendix and meets the qualifications specified in the CRA.

2.5 **Support Coordinator:** The individual who has primary responsibility for support coordination activities for a TennCare Covered Person receiving Employment and Community First (ECF) CHOICES services as specified in this Appendix and meets the qualifications specified in the CRA. In the case of ECF CHOICES Groups 7 and 8, certain Support Coordination activities shall be performed by the Integrated Support Coordination Team, as defined in the CRA.

2.6 **Independent Support Coordinator:** The individual who has primary responsibility for support coordination activities, including assistance in developing a PCSP, for a TennCare Covered Person receiving HCBS pursuant to a Section 1915(c) waiver.

2.7 **Contractor Risk Agreement (CRA) or State Contract:** The agreement between United and Division of TennCare regarding requirements for operation and administration of the managed care TennCare program, including CHOICES and/or Employment and Community First (ECF) CHOICES, for the purpose of providing and paying for Covered Services to Covered Persons enrolled in TennCare.

2.8 **Covered Person:** A person who has been determined eligible for TennCare or CoverKids and who has been enrolled with United for the provision of Covered Services under TennCare or CoverKids. A Covered Person may also be referred to as an Enrollee, Member, Customer or Patient under the Agreement. For purposes of Section 4.15, and missed visits of home health services in Section 4.15(c), "Covered Person" means not only (1) the Covered Person, (2) the Covered Person's parent, or (3) the Covered Person's legal guardian, but also a person who has a close, personal relationship with the Covered Person and is routinely involved in providing unpaid support and assistance to them.

2.9 **Covered Services:** The package of health care services, including physical health, behavioral health, and Long-Term Services and Supports, that define the covered services or benefits available to TennCare or CoverKids Enrollees enrolled with United pursuant to the State Contract.

2.10 **CoverKids:** The State Child Health plan under Title XXI of the Social Security Act State Children's Health Insurance Program.

2.11 **Fraud:** An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or some other person. It includes any act that constitutes fraud under applicable federal or state law (see 42 CFR 455.2).

2.12 **Home and Community-Based Services (HCBS):** Services that are provided pursuant to a Section 1915(c) waiver or the CHOICES or ECF CHOICES program as an alternative to long-term care institutional services in a nursing facility or an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or to delay or prevent placement in a nursing facility. HCBS may also include optional or mandatory services that are covered by Tennessee's Title XIX state plan or under the TennCare demonstration for all eligible enrollees, including home health or private duty nursing. However, only CHOICES, ECF CHOICES and Section 1915(c) waiver HCBS are eligible for Consumer Direction. CHOICES, ECF CHOICES and Section 1915(c) waiver HCBS do not include home health or private duty nursing services or any other HCBS that are covered by Tennessee's Title XIX state plan or under the TennCare demonstration for all eligible enrollees, although home health and private duty nursing services are subject to estate recovery and shall be

counted for purposes of determining whether a CHOICES member's needs can be safely met in the community within his or her individual cost neutrality cap. The cost of home health and private duty nursing shall also be counted against the member's Expenditure Cap for members in ECF CHOICES Group 6 who are granted an exception to the Expenditure Cap based on exceptional medical and/or behavioral needs, and for members enrolled in ECF CHOICES Groups 7 and 8 who also have an Expenditure Cap based on comparable cost of institutional care.

2.13 Individual Program Plan (IPP): The plan for individuals with intellectual disabilities in intermediate care facilities, developed by the facility's interdisciplinary team, which includes opportunities for individual choice and self-management and identifies: the discrete, measurable, criteria-based objectives the individual is to achieve; and the specific individualized program of specialized and generic strategies, supports, and techniques to be employed. The IPP must be directed toward the acquisition of the behaviors necessary for the individual to function with as much self-determination and independence as possible, and the prevention or deceleration of regression or loss of current optimal functional status.

2.14 Person Centered Support Plan (PCSP): The plan for individuals receiving HCBS pursuant to CHOICES, ECF CHOICES, or a Section 1915(c) waiver developed by a Support Coordinator, or with assistance of an Independent Support Coordinator, in accordance with person-centered planning requirements set forth in federal regulation, and in TennCare policies and protocols, using a person-centered planning process that accurately documents the member's strengths, needs, goals, lifestyle preferences and other preferences and outlines the services and supports that will be provided to the member to help them achieve their preferred lifestyle and goals.

2.15 Long-Term Services and Supports (LTSS): Medical and/or personal care and supportive services needed by individuals who have lost some capacity to perform activities of daily living, such as bathing, dressing, eating, transfers, and toileting, and/or activities that are essential to daily living, such as housework, preparing meals, taking medications, shopping, and managing money. Long-Term Services and Supports are provided under the CHOICES, ECF CHOICES, 1915(c) HCBS Waivers, PACE program, and to individuals in ICF/IIDs, of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the beneficiary to live or work in the setting of their choice, which may include the individual's home, a worksite, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting.

2.16 Medical Records: All medical, behavioral health, and Long-Term Services and Supports histories; records, reports and summaries; diagnoses; prognoses; records of treatment and medication ordered and given; X-ray and radiology interpretations; physical therapy charts and notes; lab reports; other individualized medical, behavioral health, and Long-Term Services and Supports documentation in written or electronic format; and analyses of such information.

2.17 Patient Liability: The amount of a Covered Person's income, as determined by the Division of TennCare, to be collected each month to help pay for the Covered Person's Long-Term Services and Supports.

2.18 Provider Manual: The TennCare Program Provider Manual is the administrative guide for providers that includes additional information, protocols and United policies. The Provider Manual is available on the website at www.uhccommunityplan.com.

2.19 Reportable Event: An event that is classified as Tier 1 or Tier 2, or Additional Reportable Events, as defined by TennCare, that must be reported to United and DIDD, as specified by TennCare, pursuant to Section A.2.15.7 of the CRA.

2.20 **State:** The State of Tennessee, including, but not limited to, any entity or agency of the state, such as the Tennessee Department of Finance and Administration, the Office of Inspector General, the Division of TennCare, the Tennessee Bureau of Investigation, Medicaid Fraud Control Unit, the Tennessee Department of Mental Health and Substance Abuse Services, Tennessee Department of Intellectual and Developmental Disabilities (DIDD), the Tennessee Department of Children's Services, the Tennessee Department of Health, the Tennessee Department of Commerce and Insurance, and the Office of the Attorney General or any other designated regulatory agencies.

2.21 **State Contract or Contractor Risk Agreement (CRA):** The agreement between United and Division of TennCare regarding requirements for operation and administration of the managed care TennCare program, including CHOICES, ECF CHOICES and CoverKids, for the purpose of providing and paying for Covered Services to Covered Persons enrolled in TennCare. The CRA is available to the Provider on the Division of TennCare website.

2.22 **TennCare or TennCare Program:** The program administered by the Division of TennCare, as designated by the State and the Centers for Medicare and Medicaid Services (CMS), pursuant to Title XIX of the Social Security Act and the Section 1115 research and demonstration waiver granted to the State of Tennessee and any successor programs. For purposes of this Appendix, references to TennCare or the TennCare Program shall include CoverKids unless otherwise specified.

2.23 **TennCare Kids (EPSDT):** The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) service is Medicaid's comprehensive and preventive child health program for individuals under the age of 21. EPSDT was defined by law as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA '89) legislation and includes periodic screening, vision, dental, and hearing services. In addition, Section 1905(r)(5) of the Social Security Act (the Act) requires that any medically necessary health care service listed at Section 1905(a) of the Act be provided to an EPSDT recipient even if the service is not available under the State's Medicaid plan to the rest of the Medicaid population. The federal regulations of EPSDT are in 42 CFR Part 441, Subpart B. In accordance with the CoverKids State Plan and Division of TennCare rules and regulations, EPSDT shall not apply to CoverKids Members.

2.24 **Tennessee Health Link:** The State defines Tennessee Health Link as a team of professionals associated with a mental health clinic or other behavioral health provider who provides whole-person, patient-centered, coordinated care for an assigned panel of Covered Persons with behavioral health conditions. Covered Persons who would benefit from Tennessee Health Link will be identified based on diagnosis, health care utilization patterns, or functional need. They will be identified through a combination of claims analysis and provider referral. Specific requirements for Providers that are Tennessee Health Link Providers are noted herein.

2.25 **Waste:** The overutilization, underutilization, or other misuse of resources that result in unnecessary costs to the Medicaid program, such as providing services that are not medically necessary.

2.26 **Federal 340B Program.** All providers who participate in the federal 340B program must give United the benefit of 340B pricing. This requirement shall be enforced in accordance with the guidance as provided by TennCare.

SECTION 3
PROVIDER REQUIREMENTS

The TennCare 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 Provision of Covered Services. Provider may not refuse to provide Medically Necessary or preventive Covered Services to a child under the age of twenty-one (21) or other Covered Persons for non-medical reasons. Provider is not required to accept or continue treatment of a patient with whom Provider feels he or she cannot establish and/or maintain a professional relationship. Provider shall follow the applicable CRA's requirements for the provision of Covered Services. Provider's decisions affecting the delivery of acute or chronic care services to Covered Persons shall be made on an individualized basis and in accordance with the following definitions:

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

ii) Emergency Services: Covered Services (inpatient and outpatient) that are as follows: (1) furnished by a provider that is qualified to furnish these services; and (2) needed to evaluate or stabilize an emergency medical condition**.** United shall provide coverage for an Emergency Medical Condition and any necessary Emergency Services, and Emergency Services shall be rendered by Provider without a requirement of prior authorization of any kind.

iii) Medically Necessary: Shall be defined by Tennessee Code Annotated, Section 71-5-144, and shall describe a medical item or service that meets the criteria set forth in that statute. The term "medically necessary", as defined by Tennessee Code Annotated, Section 71-5-144, applies to TennCare enrollees. Implementation of the term "medically necessary" is provided for in regulations at 1200-13-16, consistent with the statutory provisions, which control in case of ambiguity. No enrollee shall be entitled to receive and TennCare shall not be required to pay for any items or services that fail fully to satisfy all criteria of "medically necessary" items or services, as defined either in the statute or in regulations at 1200-13-16.

3.2 Non-Covered Services. As specified in section A.2.10 of the CRA, Provider acknowledges and agrees that, except as authorized pursuant to section A.2.6.5 of the CRA, and in accordance with applicable the Division of TennCare rules and regulations at 1200.13.13.10 and 1200.13.14.10, United shall not pay for non-Covered Services.

3.3 Scope of Practice/Services. By signing the Agreement, Provider certifies that Provider shall provide to Covered Persons only the Covered Services specified in the Agreement and that such services are within the scope of Provider's professional/technical practice.

3.4 Medicaid Eligibility; NPI. Provider must meet applicable minimum requirements for participation in TennCare, including a State Medicaid ID number as required by the Division of TennCare, and as applicable, Provider shall obtain a National Provider Identification Number (NPI). Upon notification from the State that Provider's enrollment in TennCare has been denied or

terminated, United must terminate provider immediately and will notify affected Covered Persons that Provider is no longer participating in the network.

3.5 Accessibility Standards. Provider shall comply with applicable access requirements, including but not limited to appointments and wait times, established under the CRA, as further described in the Provider Manual.

3.6 Hours of Operation; Appointments. Provider shall offer hours of operation that are no less than the hours of operation offered to commercial beneficiaries. As applicable, Provider will make Covered Services available 24 hours a day, 7 days a week when medically necessary.

3.7 Hold Harmless. As specified in section A.2.6.7 of the CRA, Provider or collection agencies acting on Provider's behalf may not bill Covered Persons for amounts other than applicable TennCare cost sharing or Patient Liability amounts for Covered Services, including but not limited to, services that the State or United has not paid for, except as permitted by the Division of TennCare rules and regulations and as described below. Providers may seek payment from a Covered Person only in the following situations:

i) If the services are not Covered Services and, prior to providing the services, Provider informed Covered Person that the services are not Covered Services. 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 acknowledgment in writing prior to rendering the service. Regardless of any understanding worked out between Provider and the Covered Person about private payment, once Provider bills United for the service that has been provided, the prior arrangement with the Covered Person becomes null and void without regard to any prior arrangement worked out with the Covered Person;

ii) If the Covered Person's TennCare eligibility is pending at the time services are provided and if Provider informs the person they will not accept TennCare assignment whether or not eligibility is established retroactively. Regardless of any understanding worked out between Provider and the Covered Person about private payment, once the provider bills United for the service the prior arrangement with the Covered Person becomes null and void without regard to any prior arrangement worked out with the Covered Person;

iii) If the Covered Person's TennCare eligibility is pending at the time services are provided, however, all monies collected, except applicable TennCare cost sharing or Patient Liability amounts shall be refunded when a claim is submitted to United because Provider agreed to accept TennCare assignment once retroactive TennCare eligibility was established. (The monies collected shall be refunded as soon as a claim is submitted and shall not be held conditionally upon payment of the claim); and

iv) If the services are not covered because they are in excess of the Covered Person's benefit limit, and Provider complies with applicable TennCare rules and regulations.

As a condition of payment, Provider shall accept the amount paid by United or appropriate denial made by United (or, if applicable, payment by United that is supplementary to the Covered Person's third party payer) plus any applicable amount of TennCare cost sharing or Patient Liability responsibilities due from the Covered Person as payment in full for the service. Except in the circumstances described above, if United is aware that Provider, or a collection agency acting on Provider's behalf, bills a Covered Person for amounts other than the applicable amount of TennCare

cost sharing or Patient Liability responsibilities due from the Covered Person, United shall notify the Provider and demand that Provider and/or collection agency cease such action against the Covered Person immediately. If Provider continues to bill a Covered Person after notification by United, United shall refer the provider to the Tennessee Bureau of Investigation. If United determines a Covered Person was charged for Covered Services inappropriately, such payment may be recovered, as applicable. For purposes of this Section 3.7, Covered Person shall include the patient, parent(s), guardian, spouse or any other legally responsible person of the Covered Person being served. This provision shall survive any termination of the Agreement, including breach of the Agreement due to insolvency.

3.8 Indemnification.

i) Provider shall indemnify and hold harmless the State as well as its officers, agents, and employees (hereinafter the "Indemnified Parties") from all injuries, deaths, claims, losses, damages, liabilities, judgements, costs (including court costs and attorney fees), expenses or suits incurred by or brought against the Indemnified Parties to the extent proximately caused by any negligent act or other intentional misconduct or omission of Provider, its agents, officers, employees, or contractors arising from the Agreement or as a result of the failure of Provider to comply with the terms of the CRA. The State shall give United and Provider written notice of each such claim or suit and full right and opportunity to conduct Provider's own defense thereof, together with full information and all reasonable cooperation; but the State does not accord to United or Provider, through its attorneys, any right(s) to represent the State of Tennessee in any legal matter, such right being governed by TCA 8-6-106. This provision shall survive any termination of the Agreement, including breach of the Agreement due to insolvency.

ii) Provider shall indemnify and hold harmless the Indemnified Parties as well as their officers, agents, and employees from all claims or suits which may be brought against the Indemnified Parties for infringement of any laws regarding patents or copyrights which may arise from Provider's or Indemnified Parties performance under the CRA. In any such action, brought against the Indemnified Parties, Provider shall satisfy and indemnify the Indemnified Parties for the amount of any final judgment for infringement. The State shall give United and Provider written notice of each such claim or suit and full right and opportunity to conduct Provider's own defense thereof, together with full information and all reasonable cooperation; but the State does not accord to United or Provider, through its attorneys, any right(s) to represent the State of Tennessee in any legal matter, such right being governed by TCA 8-6-106.

iii) While the State will not provide a contractual indemnification to Provider, such shall not act as a waiver or limitation of any liability for which the State may otherwise be legally responsible to Provider. Provider retains all of its rights to seek legal remedies against the State for losses Provider may incur in connection with the furnishing of services under the Agreement or this Appendix, in accordance with the terms of the CRA, or for the failure of the State to meet its obligations under the CRA.

This section does not apply to governmental entities that are exempt from this indemnification requirement.

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 providers, including Long-Term Services and Supports providers and all licensed medical professionals are credentialed in accordance with United's and the CRA's credentialing requirements.

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

3.11 Subcontracts. Provider shall not enter into subsequent agreements or subcontracts for any of the work contemplated under the Agreement or this Appendix without the prior written approval of United. If Provider subcontracts or delegates any functions of the Agreement, in accordance with the terms of the Agreement, the subcontract or delegation must include all of the requirements of this Appendix, and applicable requirements of the CRA and applicable laws and regulations, and subcontractor shall be subject to the same credentialing standards and audits as a contracted provider. Provider further agrees to promptly amend its agreements with such subcontractors, in the manner requested by United, to meet any additional TennCare requirements that may apply to the services. Provider agrees and acknowledges that subcontracts require prior approval by the Division of TennCare and Tennessee Department of Commerce and Insurance (TDCI).

In the event Provider does not obtain approval from United to enter into subsequent agreements or subcontracts, those subsequent agreements and/or subcontracts may be declared null and void by the Division of TennCare and claims submitted for such services shall be considered improper payments and may be considered false claims. Any such improper payment may be subject to action under Federal and State false claims statute or be subject to recoupment by United and/or Division of TennCare as overpayments.

3.12 Records Retention. As required under State or federal law or the CRA, Provider shall maintain an adequate record keeping system for recording services, charges, dates and all other commonly accepted information elements for services rendered to Covered Persons, including without limitation, all grievance and appeal records and any other records related to services provided under the State Contract. Provider shall have and maintain documentation necessary to demonstrate that Covered Services were provided in compliance with State and federal requirements. All financial records shall follow generally accepted accounting principles. Medical records and supporting management systems shall include all pertinent information related to the medical management of each Covered Person. Other records shall be maintained as necessary to clearly reflect all actions taken by the Provider related to services provided under the State Contract. Such records shall be maintained for a period of not less than ten (10) years after the termination of the Agreement. If records are under evaluation, audit, review, investigation or prosecution, they must be retained for a minimum of ten (10) years following resolution of such action (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of Covered Services performed under the Agreement and administrative, civil or criminal investigations or prosecutions).

i) Medical Records. Provider shall maintain Medical Records in a manner that is current, detailed and organized, and which permits effective and confidential patient care and quality review, administrative, civil and/or criminal investigations and/or prosecutions. Provider shall develop and maintain Medical Record keeping policies and practices which are consistent with 42 CFR Part 456 and current NCQA standards for Medical Record

documentation. Provider shall distribute these policies to any additional practice sites. At a minimum, the policies and procedures shall address:

a) confidentiality of Medical Records;

b) Medical Record documentation standards; and

c) the Medical Record keeping system and standards for the availability of Medical Records. At a minimum the following shall apply: (1) as applicable, Medical Records shall be maintained or available at the site where Covered Services are rendered; (2) Covered Persons (for purposes of behavioral health records, Covered Person includes an individual who is age sixteen (16) or over) and their legally appointed representatives shall be given access to the Covered Person's Medical Records, to the extent and in the manner provided by TCA 63-2-101, 63-2-102 and 33-3-104 *et seq.*, and, subject to reasonable charges, (except otherwise provided in the CRA) be given copies thereof upon request; (3) provisions for ensuring that, in the event a Covered Person-provider relationship with a TennCare PCP ends and the Covered Person requests that medical records be sent to a second TennCare provider who will be the Covered Person's PCP, the first provider does not charge the Covered Person or the second provider for providing the Medical Records; and (4) performance goals to assess the quality of Medical Record keeping.

ii) Behavioral Health Providers. As applicable, behavioral health providers shall maintain Medical Records in conformity with TCA 33-3-101 *et seq.* for persons with serious emotional disturbance or mental illness. Behavioral health providers shall also maintain Medical Records of persons whose confidentiality is protected by 42 CFR Part 2 in conformity with that rule or TCA 33-3-103, whichever is more stringent.

iii) General Record Keeping; Audit or Investigation. Provider acknowledges and agrees that the Division of TennCare, Department of Health and Human Services Office of Inspector General (DHHS OIG), Office of the Comptroller of the Treasury, Tennessee Bureau of Investigation, Medicaid Fraud Control Division (TBI MFCD), Office of Inspector General (OIG), Department of Justice (DOJ), and the Office of the Attorney General, as well as any authorized State or federal agency or entity or their authorized representatives may evaluate through inspection, evaluation, review or request, whether announced or unannounced, or other means any records pertinent to the Agreement, including, but not limited to, Medical Records, billing records, financial records, and/or any records related to services rendered, quality, appropriateness and timeliness of services, and /or any records relevant to an administrative, civil and/or criminal investigation and/or prosecution and such evaluation, inspection, review or request, and when performed or requested, shall be performed with the immediate cooperation of Provider. Upon request, Provider shall assist in such reviews, including the provision of complete copies of Medical Records. Any authorized State or federal agency or entity, including, but not limited to, the Division of TennCare, OIG, TBI MFCD, DHHS OIG, DOJ, Office of the Comptroller of the Treasury, and the Office of the Attorney General, may use these records and information for administrative, civil or criminal investigations and prosecutions. For purposes of clarity with respect to this Section, HIPAA does not bar disclosure of protected health information (PHI) to health oversight agencies, including, but not limited to, OIG, TBI MFCD, DHHS OIG, DOJ, and the Office of the Attorney General.

3.13 Availability of Records. Provider acknowledges and agrees that the Division of TennCare representatives and authorized federal, state and Office of the Comptroller of the Treasury personnel, including, but not limited to TennCare, the Office of the Inspector General (OIG), the Tennessee Bureau of Investigations, Medicaid Fraud Control Division (TBI MFCD), the Department of Health and Human Services, Office of Inspector General (DHHS OIG) and the Department of Justice (DOJ), the Office of the Attorney General, and any other duly authorized state or federal agency shall have immediate and complete access to all records pertaining to services provided to Covered Persons as specified in section A.2.25.5 of the CRA.

3.14 Government Inspection. Provider shall make all records (including but not limited to, financial, administrative and Medical Records) available at Provider's expense for administrative, civil and/or criminal review, audit, or evaluation, inspection, investigation and/or prosecution by authorized federal, state, and Office of the Comptroller of the Treasury personnel, including representatives from the OIG, the TBI MFCD, DOJ and the DHHS OIG, the Division of TennCare, the Office of the Attorney General, or any duly authorized state or federal agency, upon any authorized government agency's request. Any authorized government agency, including but not limited to OIG, TBI MFCD, DHHS OIG, DOJ, and the Office of the Attorney General, may use these records to carry out their authorized duties, reviews, audits, administrative, civil and/or criminal investigations and/or prosecutions. Access will be either through on-site review of records or through the mail at the government agency's discretion and during normal business hours, unless there are exigent circumstances, in which case access will be at any time. Provider shall send all records to be sent by mail to the Division of TennCare within twenty (20) business days of request unless otherwise specified by the Division of TennCare or applicable TennCare rules and regulations. Requested records shall be provided at no expense to the Division of TennCare, authorized federal, State, and Office of the Comptroller of the Treasury personnel, including representatives from the OIG, the TBI MFCD, DOJ and the DHHS OIG, the Office of the Attorney General, or any duly authorized State or federal agency. Records related to appeals shall be forwarded within the time frames specified by in the appeal process portion of the CRA. Provider acknowledges and agrees that such requests made by TennCare shall not be unreasonable. Records shall be provided by Provider to the requesting agency at no cost.

As a condition of participation in TennCare, Covered Persons and Provider shall give TennCare or its authorized representative, the Office of the Comptroller of the Treasury, and any health oversight agency, such as OIG, TBI MFCD, DHHS Office of Inspector General (DHHS OIG), DOJ, the Office of the Attorney General, and any other authorized state or federal agency, access to their records. Provider shall furnish, immediately upon request, said records for fiscal audit, medical audit, medical review, utilization review, and other periodic monitoring as well as for administrative, civil and criminal investigations or prosecutions.

TennCare or its authorized representative, the Office of the Comptroller of the Treasury, and any health oversight agency, such as OIG, TBI MFCD, DHHS Office of Inspector General (DHHS OIG), DOJ, the Office of the Attorney General, and any other authorized state or federal agency shall at any time have the right to inspect, audit, or otherwise evaluate the quality, appropriateness, and timeliness of services provided under the terms of the State Contract and any other applicable rules, including the right to inspect and audit any records or documents of Provider and its subcontractors, and the right to inspect the premises, physical facilities, and equipment where TennCare-related activities or work is conducted. The right to audit under this section exists for ten (10) years from the end date of the State Contract or from the date of completion of any audit, whichever is later.

3.15 Audit Requirements. Provider shall maintain books, records, documents, and other evidence pertaining to services rendered, equipment, staff, financial records, medical records, and the administrative costs and expenses incurred pursuant to the Agreement, as well as medical information relating to the Covered Persons as required for the purposes of audit, or administrative, civil and/or criminal investigations and/or prosecution or for the purposes of complying with the requirements set forth in the CRA. Records other than Medical Records may be kept in an original paper state or preserved on micromedia or electronic format. Medical Records shall be maintained in their original form or may be converted to electronic format as long as the records are readable and/or legible. These records, books, documents, etc., shall be available for any authorized federal, state, including, but not limited to Tenncare, OIG, TBI MFCD, DOJ and the DHHS OIG, Office of the Comptroller of the Treasury, and the Office of the Attorney General personnel during the Agreement period and ten (10) years thereafter, unless an audit, administrative, civil or criminal investigation or prosecution is in progress or audit findings or administrative, civil or criminal investigations or prosecutions are yet unresolved in which case records shall be kept until all tasks or proceedings are completed. During the CRA contract period, these records shall be available at Provider's chosen location in Tennessee subject to the written approval of United and TennCare. If the records need to be sent to TennCare, United shall bear the expense of delivery. Prior approval of the disposition of Provider's records must be requested and approved by TennCare in writing.

3.16 Privacy; HIPAA. Provider shall comply with all applicable privacy rule and security rule provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and associated implementing regulations, as may be amended from time to time, and shall safeguard information about Covered Persons in accordance with applicable federal and State privacy laws and rules including 42 CFR §438.224 and 42 CFR Part 431, Subpart F, CRA sections A.2.27 (HIPAA) and E.6 (Confidentiality), as may be amended from time to time. Provider and its employees, providers, agents and subcontractors shall maintain reasonable and appropriate administrative, technical, and physical safeguards to ensure the integrity and confidentiality of all protected health information ("PHI") it receives or possesses in the course of carrying out the responsibilities of the Agreement.

3.17 Compliance with Law. Provider shall comply with and this Agreement incorporates by reference all applicable federal and State laws including Division of TennCare rules and regulations, guidelines, consent decrees or court orders; and revisions of such laws, regulations, consent decrees or court orders shall automatically be incorporated into the Agreement as they become effective, including but not limited to the following to the extent applicable to Provider in performance of the Agreement:

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

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

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

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

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

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

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

ii) Disclosure Form to Report Lobbying: Provider shall disclose any lobbying activities using non-federal funds in accordance with 45 CFR Part 93. 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.

3.20 Conflict of Interest. Provider shall cooperate with United's policies and procedures and comply with section E.28 of the CRA related to detecting and preventing conflicts of interest from occurring at all levels.

3.21 Gratuities. By signing the Agreement, Provider certifies that no member of or delegate of Congress, nor any elected or appointed official or employee of the State, the United States General Accounting Office, DHHS, CMS, or any other federal agency has or will benefit financially or materially due to influence in obtaining the Agreement. The Agreement may be terminated by TennCare if it is determined that gratuities of any kind were offered to or received by any of the aforementioned officials or employees from Provider or its agent or employees.

3.22 Excluded Individuals and Entities. Provider and its subcontractors shall comply with 42 C.F.R § 1002, related to exclusion and debarment screening. By signing the Agreement, Provider certifies that neither it nor any of its principals, nor any providers, subcontractors or consultants or persons with an ownership or controlling interest in the Provider (an owner including the Provider himself or herself), or an agent or managing employee of the Provider, with whom Provider contracts and who are providing items or services that are significant and material to Provider's obligations under the Agreement are:

i) excluded from participation in federal health care programs under either Sections 1128 or 1156 of the Social Security Act; or

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

iii) are otherwise not in good standing with TennCare.

Provider is obligated to screen its employees and contractors ("Screened Persons") 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 screen its employees and contractors against the Social Security Master Death File. Provider shall not employ or contract with an individual or entity that has been excluded, debarred, suspended or otherwise ineligible to participate in Federal Health Care Programs or convicted of a criminal offense that falls within the realm of 42 U.S.C. § 1320a-7(a) ("Ineligible Persons"). 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 to Covered Persons. Provider can search the lists of excluded individuals (the "Exclusion Lists") on 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 (HIPDB) https://www.npdb.hrsa.gov/ and the GSA EPLS/SAM database can be accessed at https://www.sam.gov. Federal and state exclusion databases must be reviewed monthly to ensure that no employee or contractor has been excluded. United will exclude from its network any provider who has been terminated or suspended from the Medicare or Medicaid program in any state.

If Provider determines that a Screened Person has become and Ineligible Person, then Provider will take appropriate action to remove such Screened Person from responsibility for, or involvement with, Provider's professional or business operations related to the Federal Health Care Programs and shall remove such Screened Person from any position for which the Screened Person's compensation or the items or services furnished, ordered, or prescribed by the Screened Person are paid in whole or part, directly or indirectly, by Federal Health Care Programs or otherwise with Federal funds at least until such time as the Screened Person is reinstated into participation in the Federal Health Care Programs. Any unallowable Federal funds made to an excluded individual as full or partial wages and/or benefits shall be refunded to United and/or the State, as applicable.

If Provider determined that a Screened Person is an Ineligible Person charged with a criminal offense that falls within the scope of 42 U.S.C. §§ 1320a-7(a) or is proposed for exclusion during the Screened Person's employment or contract term, Provider shall take all appropriate actions to ensure that the responsibilities of that Screened Person have not and shall not adversely affect the quality of care rendered to any beneficiary, patient, or resident, or any claims submitted to any Federal Health Care Program.

3.23 Background Checks. Provider shall conduct criminal background checks, registry, and exclusion checks in accordance with State law and TennCare policy.

3.24 Disclosure. Provider shall comply and submit to United disclosure of information in accordance with the requirements, including timeframes, specified in 42 C.F.R. Part 455, Subpart B and TennCare policies and procedures. The timeframes for this requirement shall include, at a minimum, at the time of initial contracting, contract renewal, at any time there is a change to any of the information on the disclosure form, at least once every three (3) years, and at anytime upon request.

3.25 Cultural Competency and Access, Language Services and Nondiscrimination Investigation. As required by 42 CFR 438.206, Provider shall participate in United's and the State's efforts to promote the delivery of services in a culturally competent manner to all Covered Persons, including those individuals with physical or mental disabilities, with limited English proficiency and diverse cultural and ethnic backgrounds and regardless of sex. Provider shall provide information to Covered Persons regarding treatment options and alternatives, as well as information on complaints and appeals, in a manner appropriate to the Covered Person's condition and ability to understand. Provider must provide physical access, reasonable accommodations, and accessible equipment for Covered Persons with physical or mental disabilities.

3.26 Marketing. As required under State or federal law or the applicable CRA, any marketing materials developed and distributed by Provider as related to the performance of the Agreement, and any materials distributed to Covered Persons that use TennCare's name or trademark, must be submitted to United to submit to the Division of TennCare for prior approval. This prohibition shall not include references to whether or not the provider accepts TennCare.

3.27 Fraud, Waste and Abuse Prevention. As a condition of payment, Provider shall comply with section A.2.20 of the CRA and shall cooperate fully with the State's and 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 CRA and shall cooperate and assist the Division of TennCare 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.

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

Any suspected Fraud, Waste, or Abuse shall promptly be reported to UHC, the State Medicaid Program Integrity Unit or to the TBI State Medicaid Fraud Control Division. Any suspected enrollee or member Fraud, Waste, or Abuse shall promptly be reported to the Office of the Inspector General. Member or provider fraud reporting forms can be accessed at https://www.tn.gov/finance/fa-oig/fa-oig-report-fraud.html. You may also email TBI.MFCD@tn.gov or ProgramIntegrity.TennCare@tn.gov to report Fraud, Waste, or Abuse.

3.28 Data Submission.

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

ii) Encounter Data. Provider agrees to cooperate with United to comply with United's obligation to prepare timely encounter data submissions, reports, and clinical information including, without limitation, child and adolescent health check-up reporting, EPSDT encounters, and cancer screening encounters, as applicable, and such other reporting regarding Covered Services as may be required under the State Contract. Encounter data must be accurate and include all services furnished to a Covered Person, including capitated provider's data and rendering provider information. Encounter data must be

provided within the timeframes specified and in a form that meets United requirements. By submitting encounter data to United, Provider represents to United that the data is accurate, complete and truthful and, upon United's request, Provider shall certify in writing, that the data is accurate, complete, and truthful, based on Provider's best knowledge, information and belief.

iii) Claims Information. Provider shall promptly submit to United (as set forth in the Agreement) the information needed to make payment and shall identify third party liability coverage, including Medicare and other insurance, and, if applicable, shall seek such third party liability payment before submitting claims to United. Provider understands and agrees that each claim Provider submits to United constitutes a certification that the claim is true and accurate to the best of Provider's knowledge and belief and that the Covered Services are: 1) Medically Necessary; and 2) have been provided to the Covered Person prior to submitting the claim.

3.29 Mandatory Reporting of Abuse. Provider shall report suspected abuse, neglect, and exploitation of adults in accordance with TCA 71-6-103 and report suspected brutality, abuse, or neglect of children in accordance with TCA 37-1-403 and TCA 37-1-605.

3.30 TennCare Children. Provider shall not encourage or suggest, in any way, that TennCare children be placed into state custody in order to receive medical, behavioral, or Long-Term Services and Supports Covered Services.

3.31 Claims Information. United shall pay Provider upon receipt of a clean claim properly submitted by Provider within the required time frames as specified in TCA 56-32-126 and the CRA, as may be amended from time to time.

i) Payment. Provider shall promptly submit to United information needed to make payment. Provider shall have one hundred twenty (120) calendar days from the date of rendering a Covered Service to file a claim with United, except (1) in situations regarding coordination of benefits or subrogation, in which case Provider is pursuing payment from a third party or (2) if a Covered Person is enrolled in United with a retroactive eligibility date. In situations of third party benefits, the maximum time frames for filing a claim shall begin on the date that the third party documented resolution of the claim. In situations of enrollment in United with a retroactive eligibility date, the time frames for filing a claim shall begin on the date that United receives notification from the Division of TennCare of the Covered Person's eligibility/enrollment.

ii) Denial. The TennCare Provider Independent Review of Disputed Claims process shall be available to Provider to resolve claims denied in whole or in part by United as provided in TCA 56-32-126(b).

3.32 Capitation Payments. If Provider is compensated via a capitation arrangement, Provider must:

i) Immediately notify United and the Division of TennCare by certified mail, return receipt requested, if Provider becomes aware for any reason that he or she is not entitled to capitation payment for a particular Covered Person (for example, if an Covered Person dies); and

ii) Submit utilization or encounter data as specified by United so as to ensure United's ability to submit encounter data to the Division of TennCare that meets the same standards of completeness and accuracy as required for proper adjudication of fee-for-service claims.

3.33 Overpayments. Provider shall notify United of any overpayments in compliance with the Affordable Care Act and TennCare policy and procedures. Provider shall report provider-identified overpayments to United and the TennCare Office of Program Integrity (OPI) in writing and shall return such overpayment within sixty (60) days from the date the overpayment is identified. Provider shall notify United in writing of the reason for the overpayment. Overpayments that are not returned within sixty (60) days from the date the overpayment was identified may result in a penalty pursuant to State or federal law.

3.34 Health Care-Acquired/Preventable Conditions. Provider agrees that no payment shall be made for the provision of medical assistance for health care-acquired conditions and other provider-preventable conditions as may be identified by TennCare. As a condition of payment, Provider shall identify and report to United and TennCare any provider-preventable conditions in accordance with 42 CFR §§ 434.6(a)(12), 438.3(g), and 447.26.

3.35 Reserved.

3.36 Insurance Requirements. As applicable, Provider shall secure and maintain during the term of the Agreement insurance in the type and amounts appropriate to the services to be performed under the Agreement.

If Provider is a Tennessee State Agency, Provider shall not be required to provide, carry or maintain general liability insurance or medical, professional or hospital liability insurance in accordance with Title 9, Chapter 8 of the Tennessee Code Annotated. Claims against the State, or its employees, for injury, damages, expenses or attorney fees are heard and determined by the Tennessee Claims Commission or the Tennessee Board of Claims in the manner prescribed by law.

If Provider is a Local Governmental Entity as set out under the Governmental Tort Liability Act in TCA 29-20-101, et seq., and as such, has its liability limits defined by law: As a Local Governmental Entity, Provider carries no insurance; however, it is self-insured for general liability in an adequately funded Self-Insurance Program up to the limits as set out in the statute. This self-insurance is for the benefit of the Local Governmental Entity only and provides no indemnification for any other entity whatsoever. The Local Governmental Entity does not have the authority under current law to indemnify other parties. The Local Governmental Entity agrees to produce proof of adequate professional liability insurance for Provider's professional employees who perform any professional services under this Agreement.

For a Provider rendering Long-Term Services and Supports Choices Nursing Facility services, ECF CHOICES services, and/or Home and Community Based Services, that is not a Local Governmental Entity or a State Agency, and does not provide short term skilled services:

For three (3) years following the effective date of TennCare's Long-Term Services and Supports Benefit Plan ("CHOICES or ECF CHOICES HCBS") implementation (the "Implementation Period"), United shall not require Provider to have liability insurance in excess of the TennCare requirements in effect prior to the Implementation Period. At the end of the Implementation Period, this Section shall automatically be amended without further action of the parties to reflect the current CHOICES HCBS insurance requirements. If CHOICES or ECF CHOICES HCBS has not implemented insurance requirements upon expiration of the Implementation Period, the parties

agree to reevaluate and replace this paragraph with the then standard insurance requirements for similar providers. At all times, Provider agrees to maintain and provide written proof upon execution of the Agreement and at any subsequent time upon request of United of adequate insurance in such amounts as required by this paragraph. Provider agrees to notify United not less than fifteen (15) days prior to any reduction in coverage, cancellation or nonrenewal of the policy(s). The insurance required by this section shall not relieve or release Provider from, or limit its liability with respect to, any and all obligations under this Agreement.

3.37 Quality; Utilization Management. Provider agrees to participate and cooperate with any quality improvement, utilization review, and management activities established by United and/or the Division of TennCare, including actions to improve patient safety and quality. This shall include, but not be limited to, participation in any internal and external quality assurance, utilization review, peer review, and grievance procedures established by United or as required under the applicable CRA to ensure that Covered Persons have due process for their complaints, grievances, appeals, fair hearings or requests for external review of adverse decisions made by United or Provider.

3.38 Continuity of Care. In accordance with the Agreement and to the extent required by applicable law, regulations or the CRA, Provider shall cooperate with United and provide Covered Persons with continuity of treatment (which may include coordination of care as required under law) in the event Provider's participation with United terminates during the course of a Covered Person's treatment by Provider, except in the case such termination is due to adverse action against the Provider.

Covered Persons receiving Tennessee Health Link Covered Services at the start date of Tennessee Health Link program operations shall be maintained in Tennessee Health Link until such time as the Covered Person no longer qualifies on the basis of medical necessity or refuses treatment.

3.39 Appeals and Grievances. United will provide general and targeted education to Provider regarding Provider's obligations related to appeals and grievances by Covered Persons as set forth in section A.2.19 of the CRA, including, without limitation, when an emergency appeal is appropriate, and procedures for providing written certification thereof. Provider shall comply with the appeal process, including, but not limited to, the following:

i) When a grievance or fair hearing request is filed by or on behalf of a Covered Person, Provider agrees to satisfy the following obligations in relation to the Covered Person's grievance or fair hearing request:

   a. Provider must assist a Covered Person by providing appeal forms and contact information including the appropriate address, telephone number and/or fax number for submitting grievances or TennCare fair hearing requests.

   b. Provider may, with Covered Person's written consent, file a grievance or TennCare fair hearing request on Covered Person's behalf. However, provider cannot file a request for Covered Person to receive continuation of benefits.

   c. Provider agrees to timely comply with a request from Covered Person, Covered Person's representative, TennCare or United for information or records, including medical records, related to Covered Person's grievance of fair hearing request.

ii) Provider must seek advance prior authorization when Provider feels he or she cannot order a drug on the TennCare PDL. Further, Provider shall take the initiative to seek prior authorization or change or cancel the prescription when contacted by a Covered Person or pharmacy regarding denial of a pharmacy service due to system edits (e.g., therapeutic duplication, etc.).

iii) Unless the State Contract requires otherwise, the appeals and grievances requirements above shall not apply to CoverKids Members. Review of CoverKids decisions shall be governed by TennCare Division rule 1200-13-21-.07 in accordance with T.C.A. §§ 4-5-202, 71-3-1106, 71-3-1110, and the Tennessee Title XXI Children's Health Insurance Program State Plan.

3.40 RESERVED

3.41 No Payment Outside U.S. Provider agrees that all Covered Services to be performed herein shall be performed in the United States of America and Provider agrees that United shall not provide any payments for items or services provided under the Agreement to any financial institution or entity located outside the United States of America. Furthermore, Provider is prohibited to transfer member data in any form via any medium to any third party beyond the boundaries and jurisdiction of the United States without the prior written consent of United.

3.42 Non-Discrimination. In performance of obligations under the Agreement and in employment practices, Provider shall not exclude, deny benefits or otherwise subject to discrimination, nor use any policy or practice that has the effect of discriminating against, any persons on the grounds of 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, TennCare applicants, and Enrollees. The Provider agrees to interacting with individuals from diverse cultural backgrounds including, individuals with LEP, individuals with low literacy, individuals with disabilities, including individuals with vision, cognitive, hearing, and speech disabilities. Provider shall have policies and procedures for delivering services in a nondiscriminatory and cultural competent manner, providing free language and communication assistance services to individuals, providing individuals with reasonable accommodations, discrimination complaint procedures, and for regularly inspecting assessment methods and decision support tools like algorithms to promote equity and eliminate bias with generating assessment results. Provider's staff members carrying out the terms of the provider agreement shall receive annual training on the Provider entity's: policies on how to deliver services in a nondiscriminatory and culturally competent manner, complaint procedures, process to obtain free language assistance services for LEP individuals, process for providing free effective communication services (auxiliary aids or services) to individuals with disabilities, and process for providing reasonable accommodations for individuals with disabilities. The Provider entity's new hires carrying out the terms of the Provider agreement shall receive this training within thirty (30) days of joining the entity's workforce.

Provider shall provide any discrimination complaint received relating to TennCare's services and activities within two (2) days of receipt to TennCare's Office of Civil Rights Compliance ("OCRC") at HCFA.Fairtment@tn.gov. Provider agrees to cooperate with OCRC and other federal and state authorities during discrimination complaint investigations and to assist individuals in obtaining information on how they can report a complaint or get assistance for a disability related need that involves TennCare's services or activities by contacting OCRC. To satisfy this obligation Provider may direct the individual to OCRC's webpage at: https://www.tn.gov/tenncare/members-

applicants/civil-rights-compliance.html, to call TennCare Connect at 855-259-0701, or to the member's MCO if the member needs assistance with filing a complaint.

3.43 Adverse Occurrences. Provider shall report adverse occurrences, including death, to United in accordance with applicable State requirements. The maximum timeframe for reporting an adverse occurrence to United shall be twenty-four (24) hours.

3.44 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 of otherwise required by law.

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

3.46 Electronic and Information Technology. To the extent that Provider is using electronic and information technology to fulfill its obligations under this Contract, Provider agrees to comply with the electronic and information technology accessibility requirements under the federal civil rights laws including Section 504 and Section 508 of the Rehabilitation Act of 1973 ("Section 508"), the Americans with Disabilities Act, and 45 C.F.R. pt. 92 (or any subsequent standard adopted by an oversight administrative body, including the Federal Accessibility Board). To comply with the accessibility requirements for Web content and non-Web electronic documents and software, Provider shall use the most current W3C's Web Content Accessibility Guidelines ("WCAG") level AA or higher with a goal to transition to WCAG 3 level silver (For the W3C's guidelines see: https://www.w3.org/WAI/standards-guidelines/ and Section 508 standards: https://www.access-board.gov/ict/). If applicable under the Agreement, Provider agrees to comply with Title VI of the Civil Rights Act of 1964, by adding a system function that allows users to translate the content into a language other than English. This requirement may be satisfied by the provision of a link to a machine translate tool, technology solution, or translating the page into non-English languages as directed by the Division of TennCare.

SECTION 4
ADDITIONAL PROVIDER REQUIREMENTS FOR SPECIFIC ACTIVITIES

4.1 Prenatal/Obstetric Care.

i. As applicable to Provider, unreasonable delay in providing care to a pregnant Covered Person seeking prenatal care shall be considered a material breach of the Agreement. For purposes of this Section 4.1, "unreasonable delay" shall mean failure of the prenatal care provider to meet the appointment availability requirements established under section A.2.11.5 of the CRA, as further described in the provider manual.

ii. As applicable to Provider, as a condition to reimbursement for global procedures codes for obstetric care, Provider shall submit utilization or encounter data as specified by United in a timely manner to support the individual services provided.

4.2 Laboratory Services. If Provider performs laboratory services, Provider shall meet all applicable requirements of the Clinical Laboratory Improvement Amendments (CLIA) of 1988.

4.3 **CHOICES Program.** If Provider renders Covered Services to Covered Persons under TennCare's program for Long-Term Services and Supports for individuals 65 and older and/or persons with physical, intellectual, or developmental disabilities, Provider shall notify United, in accordance with United's processes, as expeditiously as warranted by the Covered Person's circumstances, of any known significant changes in the Covered Person's condition or care, hospitalizations, or recommendations for additional services. United shall in turn notify the Covered Person's Care/Support Coordinator/ISC/DIDD Case Manager.

4.4 **ECF CHOICES Program and Section 1915(c) waiver.** If Provider renders Covered Services to Covered Persons under TennCare's program for people with Intellectual and/or Developmental Disabilities, Provider shall facilitate notification of the Covered Person's Support Coordinator by notifying United, in accordance with United's processes, as expeditiously as warranted by the Covered Person's circumstances, of any known significant changes in the Covered Person's condition or care, hospitalizations, or recommendations for additional services.

4.5 **Hospitals.** If Provider is a hospital, including a psychiatric hospital, Provider shall cooperate with United in developing and implementing protocols as part of United's nursing facility and ICF/IID diversion plan, which shall include, at a minimum, a hospital's obligation to promptly notify United upon admission of an eligible Covered Person regardless of payor source for the hospitalization, how a hospital will identify members who may need home health, private duty nursing, nursing facility or HCBS upon discharge, and how a hospital will engage United in the discharge planning process to ensure that Covered Persons receive the most appropriate and cost-effective medically necessary services upon discharge.

4.6 **Pharmacy Services.** Provider shall coordinate with the TennCare pharmacy benefits manager (PBM) regarding authorization and payment for pharmacy services.

4.7 **Nursing Facility.** If Provider is a nursing facility, in addition to the other requirements set forth in the Agreement or this Appendix, Provider shall:

i) Promptly notify United, and/or the State as directed by the Division of TennCare, of a Covered Person's admission or request for admission to the nursing facility regardless of payor source for the nursing facility stay, or when there is a change in a Covered Person's known circumstances. Provider shall also notify United, and/or the State as directed by Tenncare, prior to a Covered Person's discharge from the nursing facility;

ii) Provide written notice to the Division of TennCare and United in accordance with State and federal requirements before voluntarily terminating the Agreement. Provider shall comply with all applicable State and federal requirements regarding voluntary termination;

iii) Notify United immediately if Provider is considering discharging a Covered Person. Provider shall consult with the Covered Person's Care Coordinator to intervene in resolving issues if possible. If Provider is not able to resolve such issues, Provider shall prepare and implement a discharge and/or transition plan as appropriate;

iv) Notify a Covered Person and/or a Covered Person's representative (if applicable) in writing prior to discharge in accordance with State and federal requirements;

v) Provider shall accept payment or appropriate denial made by United (or, if applicable, payment by United that is supplementary to the Covered Person's third party payer) plus

the amount of any applicable Patient Liability, as payment in full for services provided and shall not solicit or accept any surety or guarantee of payment from a Covered Person in excess of the amount of applicable Patient Liability. For purposes of this Section 4.7(v), Covered Person shall include the patient, parent(s), guardian, spouse or any other legally responsible person of the Covered Person being served;

vi) Provider's responsibilities regarding a Covered Person's Patient Liability as specified in sections A.2.6.7 and A.2.21.5 of the CRA, which shall include but not be limited to collecting the applicable Covered Person Patient Liability amounts from CHOICES Group 1 members, notifying the Covered Person's Care Coordinator if there is an issue with collecting a Covered Person's Patient Liability, and making good faith efforts to collect payment;

vii) Provider shall timely seek certification and recertification (as applicable) of a Covered Person's level of care eligibility for Level I and/or Level II nursing facility care and shall cooperate fully with United in the completion and submission of the level of care assessment;

viii) Provider shall notify United of any change in a Covered Person's medical or functional condition that could impact the Covered Person's level of care eligibility for the currently authorized level of nursing facility services;

ix) Provider shall submit complete and accurate Pre-Admission Evaluations (PAEs) to United that satisfy all technical requirements specified by TennCare, and accurately reflect the Member's current medical and functional status, including Safety Determination Requests. The nursing facility shall also submit all supporting documentation required in the PAE and *Safety Determination Request Form*, as applicable and required pursuant to TennCare Rules.

x) Provider shall comply with State and federal laws and regulations applicable to nursing facilities as well as any applicable court orders, including, but not limited to, those that govern admission, transfer, and discharge policies;

xi) Provider shall comply with federal Preadmission Screening and Resident Review (PASRR) requirements applicable to all CHOICES nursing facility residents, regardless of payor source, including that a level I screening be completed prior to admission, a level II evaluation be completed prior to admission when indicated by the level I screening, and a review be completed based upon a significant physical or mental change in the resident's condition that might impact a Covered Person's need for or benefit from specialized services;

xii) Provider shall collaborate with United and other providers as needed to help ensure that current information regarding the Covered Person's mental health or intellectual disabilities needs (as available) is reflected in the PASRR screening in order to support an appropriate PASRR determination;

xiii) Provider shall cooperate with United in developing and implementing protocols as part of United's CHOICES nursing facility diversion and transition plans, which shall include, at a minimum, Provider's obligation to promptly notify United upon a admission or request for admission of an eligible Covered Person regardless of payor source for the CHOICES

nursing facility stay, how Provider will assist United in identifying residents who may want to transition from CHOICES nursing facility services to CHOICES HCBS; Provider's obligation to promptly notify United regarding all such identified members, and how Provider will work with United in assessing a Covered Person's transition potential and needs and in developing and implementing a transition plan (as applicable);

xiv) Provider shall coordinate with United in complying with the requirements in 42 C.F.R. 483.75, regarding written transfer agreements and shall use contract providers when transfer is medically appropriate, except as authorized by United or for emergency services;

xv) Provider shall have on file a system designed and utilized to ensure the integrity of a Covered Person's personal financial resources. This system shall be designed in accordance with the regulations and guidelines set out by the Comptroller of the Treasury and the applicable federal regulations;

xvi) Provider shall specify to United whether it will be contracted to provide SNF services at an Enhanced Respiratory Care (ERC) rate for ventilator weaning, chronic ventilator care, and/or tracheal suctioning in addition to standard NF and SNF services (each level of ERC reimbursement must be uniquely identified). If Provider does enter into an agreement for SNF services at an enhanced rate for ventilator weaning, chronic ventilator care, and/or tracheal suctioning, including sub-acute and secretion management, Provider is required to be licensed by the Tennessee Department of Health to provide such specialized ERC, certified by CMS for program participation, and compliant with threshold standards of care for the applicable type of ERC and requirements for ERC reimbursement established by TennCare.

xvii) Provider shall immediately notify United of any changes in its license to operate as issued by the Tennessee Department of Health as well as any deficiencies cited during the federal certification process;

xviii) If Provider is involuntarily decertified by the Tennessee Department of Health or CMS, the Agreement will be automatically terminated in accordance with federal requirements; and

xix) The Agreement shall be assignable from United to the State, or its designee, at the State's discretion upon written notice to United and Provider. Further, Provider agrees to be bound by any such assignment, and the State, or its designee, shall not be responsible for past obligations of United.

xx) In the event there is a proposed change of ownership with any Nursing Facility, the new provider shall provide to the Division of TennCare documents sufficient to obtain a Medicaid ID based on appropriate documentation submitted by the new provider. United shall, subject to T.C.A 71-5-1412, enter into a provider agreement with the new provider prior to the effective date of the change of ownership. A new provider with a Medicaid ID and a provider agreement with United, which shall include, but not be limited to, the assumption of the previous owner's agreement, a new agreement with United, or a single case agreement, shall be reimbursed at one hundred percent (100%) from the effective date of the change of ownership. For purposes of nursing facility changes of ownership only, United may provisionally credential the new provider based on credentialing completed for the previous provider to enable execution of an agreement prior to the change of ownership. In cases where the United utilizes provisional credentialing, United will

subsequently conduct credentialing of the provider in accordance with the State Contract once the change of ownership process has fully concluded (including any actions related to licensure and/or certification). A new provider with a change of ownership that has not acquired a Medicaid ID shall not be reimbursed, including retroactively, until such provider acquires a Medicaid ID.

4.8 CHOICES, ECF CHOICES, or Section 1915(c) waiver HCBS Providers. If Provider is a CHOICES, ECF CHOICES or Section 1915(c) waiver HCBS provider, in addition to the other requirements set forth in the Agreement or this Appendix, Provider shall:

i) Provide at least sixty (60) days advance notice to United when Provider is no longer willing or able to provide services to a Covered Person, including the reason for the decision. Provider shall cooperate with the Covered Person's Care or Support Coordinator, Support Coordinator, Independent Support Coordinator, or DIDD Case Manager to facilitate a seamless transition to alternate providers;

ii) In the event that a CHOICES, ECF CHOICES or 1915(c) waiver HCBS provider change is initiated for a Covered Person, regardless of any other provision of the Agreement, Provider shall continue to provide services to the Covered Person in accordance with the Covered Person's person-centered support plan ("PCSP"), as appropriate, until the Covered Person has been transitioned to a new provider, as determined by United, or as otherwise directed by United, which may exceed sixty (60) days from the date of notice to United, unless the Covered Person refuses continuation of services, the Covered Person's health and welfare would be otherwise at risk by remaining with Provider, or if continuing to provide services is reasonably expected to place staff that would deliver services at imminent risk of harm. Prior to discontinuing services to the Covered Person, or prior to Provider's termination of the Agreement, as applicable, Provider shall:

a) Provide a written notification of the planned service discontinuation to the Covered Person, his/her conservator or guardian, and his/her support coordinator, no less than sixty (60) days prior to the proposed date of service discontinuation or termination of the Agreement;

b) Obtain United's written approval, in the form of a signed PCSP, to discontinue the services and cooperate with the transition to any subsequent, authorized service provider as is necessary; and

c) Consult and cooperate with United in the preparation of a discharge plan for all Covered Persons receiving care and service from Provider in the event of a proposed termination of service. When appropriate, as part of the discharge plan, Provider shall meet, consult and cooperate with any new providers to ensure continuity of care and as smooth a transition as possible.

iii) Provider's reimbursement shall be contingent upon the provision of Covered Services to an eligible Covered Person in accordance with applicable federal and state requirements and the Covered Person's plan of care as authorized by United, and must be supported by detailed documentation of service delivery to support the amount of services billed, including at a minimum, the date, time and location of service, the specific HCBS provided, the name of the Covered Person receiving the service, the name of the staff person who delivered the service, the detailed tasks and functions performed as a component of each service, notes for other caregivers (whether paid or unpaid) regarding the member or

his/her needs (as applicable), and the initials or signature of the staff person who delivered the service - – electronic visit verification that fully comports with the 21st Century Cures Act and TennCare requirements shall be deemed sufficient to meet this requirement;

iv) CHOICES or ECF CHOICES HCBS Provider shall immediately report any deviations from a Covered Person's service schedule to the Covered Person's Care or Support Coordinator;

v) Provider shall use the electronic visit verification system specified by United in accordance with United's requirements;

vi) Upon acceptance by Provider to provide approved services to a Covered Person as indicated in the Covered Person's PCSP, as appropriate, Provider shall ensure that it has staff sufficient to provide the service(s) authorized by United in accordance with the Covered Person's PCSP, as appropriate, including the amount, frequency, duration and scope of each service in accordance with the Covered Person's service schedule;

vii) Provider shall provide back-up for its own staff if a staff member is unable to fulfill an assignment for any reason. Provider shall ensure that back-up staff meet the qualifications for the authorized Covered Service;

viii) Provider is prohibited from requiring a Covered Person to choose Provider as a provider of multiple services as a condition of providing any service to the Covered Person;

ix) Provider is prohibited from soliciting Covered Persons to receive services from Provider, including:

a) Referring an individual for CHOICES or ECF CHOICES screening and intake with the expectation that, should CHOICES or ECF CHOICES enrollment occur, Provider will be selected by the Covered Person as the service provider; or

b) Communicating with existing CHOICES, ECF CHOICES or Section 1915(c) waiver members via telephone, face-to-face or written communication for the purpose of petitioning the Covered Person to change providers;

c) Communicating with hospitals, discharge planners or other institutions for the purposes of soliciting potential CHOICES, ECF CHOICES or Section 1915(c) waiver members that should instead be referred to the person's MCO, AAAD or DIDD, as applicable;

x) Provider shall comply with Reportable Event reporting and management requirements as prescribed by TennCare, including those specified in Section A.2.15.7 of the CRA;

xi) Provider is not required to have liability insurance in excess of TennCare requirements in effect prior to the implementation of CHOICES or ECF CHOICES;

xii) Provider may not alter any official CHOICES, ECF CHOICES or 1915(c) waiver brochures or other materials unless United has submitted a request to do so to TennCare and obtained prior written approval from TennCare in accordance with section A.2.17 of the CRA;

xiii) Provider may not reproduce CHOICES or ECF CHOICES logos for its own use unless United has submitted a request to do so to TennCare and obtained prior written approval from TennCare; and

xiv) CHOICES, ECF CHOICES and 1915(c) waiver HCBS Providers are required to submit copies of current licensure and/or certification to United or to DIDD (as applicable);

xv) Provider will maintain compliance with the HCBS Settings Rule detailed in 42 C.F.R. § 441.301(c)(4)-(5).

xvi) If Provider is utilizing the Electronic Visit Verification (EVV) System, Provider shall ensure that all HCBS workers complete and submit worker surveys upon logging out of each visit using a format and in a manner prior approved by TennCare.

xvii) In the event there is a proposed change of ownership of Provider, the new provider shall provide to the Division of TennCare documents sufficient to obtain a Medicaid ID based on appropriate documentation submitted by the new provider and any managed care contractor previously contracted with the former owner or operator. United and the new provider shall negotiate a new provider agreement in good faith. A new provider with a Medicaid ID and an executed contract with United, which shall include, but not be limited to, the assumption of the previous owner's contract, a new contract with United, or a single case agreement, shall be reimbursed at one hundred percent (100%) from the effective date of the change of ownership. A new provider with a Medicaid ID, but without an executed contract with United, shall be reimbursed eighty percent (80%) from the effective date of the change of ownership, with a retroactive payment to the effective date of the change of ownership of an additional twenty percent (20%) due after the execution of a contract with United. A new provider with a change of ownership that has not acquired a Medicaid ID shall not be reimbursed, including retroactively, until such provider acquires a Medicaid ID.

xviii) If DIDD is providing quality monitoring for Provider, as specified by TENNCARE, Provider must cooperate with all quality monitoring processes and requirements as described within this Appendix, the State Contract and/or TENNCARE quality monitoring protocols.

xix) Support Coordination provider agencies shall:

a) Ensure that all person employed to render support coordination services (Independent Support Coordinators or ISCs) receive effective guidance, mentoring, and training, including all training required by TENNCARE and DIDD. Effective training shall include opportunities to practice support coordination duties in a manner that development and mastery of essential job skills. The intent of providing independent support coordination is to ensure that planning and coordination of services is conflict-free. Thus, providers of independent support coordination services are prohibited from providing both support coordination and other direct waiver services. Support Coordination providers must maintain an office in each grand region where services are provided.

b) Provide Support Coordination services in a manner consistent with the 1915(c) waiver, TennCare rules, policies, and protocols and the State Contract.

c) Provide Support Coordination services in a manner that ensures person-centered planning processes and practices are followed in compliance with 42 CFR § 438.208 and 42 C.F.R. § 441.301(c)(4)-(6) and that comports fully with standards applicable to person-centered planning for services delivered under Section 1915(c) of the Social Security Act.

d) Initiate and oversee at least annual reassessment of the individual's level of care eligibility, including initial and at least annual assessment of the individual's experience to confirm that that the setting in which the individual is receiving services and supports comports fully with standards applicable to HCBS settings delivered under Section 1915(c) of the Social Security Act, including those requirements applicable to provider-owned or controlled homes, except as supported by the individual's specific assessed need and set forth in the PCSP.

e) Support the individual's informed choice regarding services and supports they receive, providers who offer such services, and the setting in which services and supports are received which shall be integrated in, and support full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS;

f) Coordinate with United to support any person supported receiving HCBS and enrolled in the Statewide or CAC Waivers planning and implementing as seamless a transition as possible from EPSDT benefits to adult benefits, including any coordination of 1915c HCBS with State Plan HCBS – Home Health and Private Duty Nursing services, as applicable, and in accordance with the State Contract or TennCare policies and protocols.

g) Ensure compliance with and reporting of specified waiver performance measures related to the PCSP, including:

PCSP inclusion of a risk assessment;

PCSP inclusion of a medical assessment, whether applicable;

PCSP review and revision, as needed, prior to the annual due date;

PCSP revisions completed as needed to address member’s changing needs; and

Ensure member received services for the amount, duration, and frequency as well as type and scope specified in the approved PCSP.

h) Track and report individual quality outcomes data as required by TENNCARE to measure provider and system performance.

i) United shall require that all 1915(c) waiver Independent Support Coordination providers participate in education and training activities as required by United to understand physical and behavioral health benefits, and collaborate with United to ensure continuity and coordination among physical health, behavioral health, and long-term services and supports, and to ensure collaboration among physical

health, behavioral health, and long-term services and supports providers pursuant to protocols, policies and procedures developed or approved by TENNCARE.

If Provider is a CHOICES or ECF CHOICES HCBS provider who renders PERS, assistive technology, minor home modifications, or pest control services, Provider shall meet all the requirements of the State Contract, the Agreement and this Appendix, applicable to Provider's services under the Agreement.

4.9 TennCare Kids Services. As applicable to Provider, Provider acknowledges and agrees that Provider is aware of the benefits that TennCare Kids offers and which requires Provider to make treatment decisions based upon children's individual medical and behavioral health needs, in accordance with the requirements of Section A.2.7.6 of the CRA, which are incorporated into this Appendix and shall be provided to Provider upon request.

4.10 Local Health Department. If Provider is a local health department, Provider shall meet all the requirements of the Agreement and this Appendix (except those that apply to nursing facilities and HCBS providers). In addition, the following apply for the purpose of TennCare Kids screening services:

i) Provider agrees to timely submit encounter data to United;

ii) United agrees to timely process claims for services in accordance with CRA Section A.2.22.4;

iii) Provider may terminate the Agreement for cause with thirty (30) days advance notice; and

iv) United agrees that prior authorization shall not be required for the provision of TennCare Kids screening services.

4.11 Referrals to Specialty Care Providers. If Provider is a Primary Care Physician ("PCP"), Provider will arrange for referrals to specialty care providers pursuant to the referral policies and procedures as described in the Provider Manual. Providers who are specialty care providers will comply with referral requirements, including but not limited to the following:

i) Maintain good communications with the Covered Person's PCP and contact the Covered Person's PCP if diagnosis or treatment required differs significantly from expectations indicated on the referral form;

ii) Respond in a timely manner to the Covered Person's PCP with summary of findings, test results, and recommendations following referral;

iii) Notify the Covered Person's PCP of the need for secondary referral within the TennCare network of physicians. Referral to other physicians outside of the TennCare network should be preceded by consultation and agreement with the Covered Person's PCP unless in the case of a medical emergency; and

iv) Hospitalize a Covered Person only with the knowledge and agreement of the Covered Person's PCP or in the case of medical emergency.

4.12 Reserved.

4.13 Ethical and Religious Directives. Should United contract with Provider to deliver services to TennCare Members pursuant to the United's obligations under the CRA and the Provider cannot provide a TennCare covered service because of its Ethical and Religious Directives or its conscience and religious beliefs, United shall provide a list of these services to TennCare. This list shall be used by United and TennCare to provide information to TennCare Members about where and how the Members can obtain the services that are not being delivered due to Ethical and Religious Directives or its conscience and religious beliefs. Should an issue arise during a service visit where Provider cannot provide a service due to Ethical and Religious Directives or its conscience and religious beliefs, Provider shall inform the TennCare Member that United has additional information on providers and procedures that are covered by TennCare. Provider is not required to make specific recommendations or referrals to the Member.

4.14 ECF CHOICES and/or CHOICES CLS, CLS-FM, Section 1915(c) Providers. If Provider is an ECF CHOICES and/or CHOICES CLS, CLS-FM, or Section 1915(c) provider in addition to the other requirements set forth in the Agreement or this Appendix, the following provision shall apply:

i) Residential Providers, shall develop and maintain policies concerning fire evacuation and natural disasters, including ensuring staff are knowledgeable about evacuation procedures and any available safety equipment (e.g., fire extinguishers).

ii) Provider shall routinely monitor the maintenance of a sanitary and comfortable living environment and/or program site, and shall develop and maintain policies for staff to identify and report any individual or systemic problems identified. Additionally, all CLS-FM Providers must complete a DIDD-compliant home study and a current DIDD Family Model Residential Supports Initial Site Survey prior to member placement.

iii) Providers with provider-owned vehicles (including employee-owned vehicles used to transport members) shall develop and maintain policies to routinely inspect such vehicles, including adaptive equipment used in such vehicles, and report and resolve any deficiencies with these vehicles.

iv) Provider shall designate a staff member as an Reportable Event Management Coordinator who shall be trained on Reportable Event processes by the United as prescribed by TennCare. Such staff member shall be the Provider's lead for Reportable Events, be primarily responsible for tracking and analyzing Reportable Events pursuant to Section A.2.15.7.1.2, and be the United's main point of contact at the Provider agency for Reportable Events.

v) Provider shall develop and maintain a crisis intervention policy that is consistent with TennCare requirements and approved by United. As applicable, policies shall include instructions for the use of psychotropic medications and behavioral safety interventions.

vi) Providers shall develop and maintain a complaint resolution process, which includes, but is not limited to the following: designation of a staff member as the complaint contact person; maintenance of a complaint log; and documentation and trending of complaint activity. Provider's policies and procedures concerning the complaint resolution process shall be available to the United upon request.

vii) As applicable, Providers providing assistance to a Covered Person with medication administration shall develop and maintain policies to ensure any medications are provided and administered by trained and qualified staff consistent with a physician's orders. Provider shall ensure that medication administration records are properly maintained, and that all medication is properly stored and accessible to Covered Persons when needed. Such Providers shall also develop and maintain policies to track and trend medication variance and omission incidents to analyze trends and implement preventions strategies.

viii) Provider shall develop and maintain policies approved by United that ensure Covered Persons are treated with dignity and respect, including ensuring staff obtain certification (as applicable) and training on person-centered practices and other topics as may be required pursuant to TENNCARE guidance or as otherwise required by the programs. Such policies shall include, but are not limited to:

a) Ensuring Covered Persons/representatives and family are given the opportunity to participate in the selection and evaluation of their direct support staff, if applicable;

b) Soliciting Covered Person/representative and family feedback on Provider services;

c) Ensuring the Covered Person/representative has information to make informed choices about available services;

d) Ensuring Covered Persons are allowed to exercise personal control and choice related to their possessions;

e) Supporting Covered Persons in exercising their rights;

f) Periodically reviewing Covered Persons' day services and promoting meaningful day activities, if applicable;

g) Supporting the Covered Person in pursuing employment goals; and

h) Only restricting Covered Persons' rights as provided in the Covered Person's person-centered support plan.

ix) Residential Providers shall develop and maintain policies to ensure that Covered Persons have good nutrition while being allowed to exercise personal choice and that Covered Persons' dietary and nutritional needs are met.

x) Providers shall ensure that staff have appropriate, job-specific qualifications and shall verify prior to and routinely during employment that Provider staff have all required licensure and certification. Additionally, all Providers shall ensure that staff receives ongoing supervision consistent with staff job functions. Providers shall ensure that the composition of the Provider board of directors or community advisor group, as applicable, reflects the diversity of the community that the Provider serves and is representative of the people served.

xi) Residential Providers shall have policies and procedures to manage and protect Covered Persons' personal funds that comport with all applicable United and TennCare policies, procedures and protocols.

xii) Providers shall carry adequate liability and other appropriate forms of insurance, which shall include, but is not limited to, the following:

a) Workers' Compensation/ Employers' Liability (including all States' coverage) with a limit not less than seven hundred fifty thousand dollars ($750,000.00) per occurrence for employers' liability.

b) Comprehensive Commercial General Liability (including personal injury & property damage, premises/operations, independent Provider, contractual liability and completed operations/products coverage) with bodily injury/property damage combined single limit not less than seven hundred fifty thousand dollars ($750,000.00) per occurrence and one million, five hundred thousand dollars ($1,500,000.00) aggregate.

c) Automobile Coverage (including owned, leased, hired, and non-owned vehicles coverage) with bodily injury/property damage combined single limits not less than one million, five hundred thousand dollars ($1,500,000.00). ECF CHOICES providers requiring this coverage are limited to those expected to transport the member as a component of service delivery, as follows: individual and small group employment supports (including pre-employment services), personal assistance, supportive home care, community integration support services, community transportation, independent living skills training, community living supports, and community living supports-family model.

xiii) CHOICES and I/DD MLTSS Programs Providers shall allow DIDD staff access to pertinent Choices and I/DD MLTSS Program member documentation. in order for DIDD to perform its oversight role (applicable in CHOICES for Reportable Event Management and Quality Monitoring for specified services).

xiv) CHOICES and I/DD MLTSS Programs Providers are required to comply with DIDD investigations as prescribed by TennCare protocol.

4.15 Home Health Agencies. If Provider is a home health agency ("HHA"), in addition to the other requirements set forth in the Agreement or this Appendix, the following provisions shall apply.

i) Provider shall comply with the federal regulations delineating the conditions of participation that HHAs must meet in order to participate in the Medicaid program.

ii) Provider shall supply each Covered Person with the following:

a) Written and verbal notice of the Covered Person's rights and responsibilities as a home health patient as required under 42 CFR §484.50(a);

b) Written and verbal notice of Provider's policy for transfer and discharge as required under 42 CFR §484.50(d), including an explanation in plain language that disruptive, abusive, or uncooperative behaviors could give rise to a "discharge for cause," and the requirements that must be satisfied by Provider in order for transfer or a discharge to be effectuated;

c) Written and verbal notice of Provider's obligation to accept complaints made by the Covered Person about the care that is (or fails to be) furnished, and of Provider's obligation to investigate, document, and resolve these complaints (as well as complaints of mistreatment, neglect, or verbal, mental, sexual, and physical abuse, or injuries of unknown source, or misappropriation of the Covered Person's property by anyone furnishing care on behalf of Provider), as required under 42 CFR §484.50(e);

d) An explanation of the scope of the home health services that the Covered Person will be receiving. Afterwards, Provider must obtain the signature of the Covered Person verifying that a Provider staff member has explained the scope of services to the Covered Person. Likewise, Provider must obtain, as required under 42 C.F.R. § 484.50(a)(2), the Covered Person's or the legal representative's signature confirming that they received written notice of the Covered Person's rights and responsibilities as required by Section 4.15(ii)(a). Provider must maintain all signature(s) in their record of the Covered Person.

iii) **Missed Visits.**

a) Provider must develop a back-up plan for each Covered Person to be implemented during missed visits, or when otherwise necessary. For purposes of this section, "missed visit," refers to a period of one or more hours that a staff member of Provider does not furnish the home health service that a Covered Person is authorized to receive and which has been implemented. A missed visit may be due to exigent circumstances beyond any party's control. It may also be due to a fault of Provider, the staff member, or United. It may also be due to a fault of the Covered Person. For example, the Covered Person refuses to allow the staff member to enter the home or to remain there after beginning work; the staff member suspects or witnesses unlawful activity in the home; or, the environment in the Covered Person's home is such that the staff member fears for their personal safety.

b) When Provider is notified before a missed visit occurs or as it is occurring, Provider must contact the Covered Person and implement the back-up plan or offer a suitable alternative service. Provider must report all missed visits to United in writing within three calendar days of the missed visit. This report must be submitted on a United-approved form, which captures all of the information United requires, including, but not limited to, the following: the identity of the Covered Person; the type of service involved; the date of the missed visit; the cause(s); and, what corrective action was taken to mitigate the cause(s) of the missed visit. Provider must ensure that the staff member enters notes about the circumstances of a missed visit in every instance in which notes are possible.

iv) When a conflict arises between a Covered Person and an assigned Provider staff member, or when a Covered Person refuses to allow an assigned staff member to begin or to complete their assigned visit, the staff member will immediately notify Provider. Once notified, Provider will contact the Covered Person and offer to either (1) implement the existing back-up plan or (2) staff the care with a qualified alternative staff member. In every instance, Provider must record these missed visits, as described above, and timely submit them to United. All of the aforementioned facts should be included in the reports with as much written explanation as possible regarding the causes and factors contributing

to the conflict. If additional conflicts arise between the Covered Person and Provider or alternative staff member (for example, if a Covered Person refuses to admit the alternative staff member into Covered Person's home), Provider must notify United and must continue making reasonable efforts to staff the approved care with qualified alternative staff members until Provider, in its discretion, plans to discharge the Covered Person for cause. At that point, Provider must notify United of its decision to discharge or transfer the Covered Person.

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

4.17 Intermediate Care Facility for Individuals with Intellectual Disabilities Providers. If Provider is an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IDD) provider, in addition to the other requirements set forth in the Agreement or this Appendix, Provider shall:

i) Promptly notify United, and/or State entity as directed by the Division of TennCare, of a Covered Person's request for admission to the ICF/IID or when there is a change in a Covered Person's known circumstances and to notify United, and/or State entity as directed by Division of TennCare, prior to a member's discharge;

ii) Not admit any person to an ICF/IID for whom Medicaid reimbursement will be sought prior to completion of a Community Informed Choice process as prescribed by Division of TennCare, and approval of such admission by the State;

iii) Provide written notice to the Division of TennCare and United in accordance with state and federal requirements before voluntarily terminating the agreement and to comply with all applicable state and federal requirements regarding voluntary termination;

iv) Notify United prior to beginning to develop an involuntary discharge plan and to consult with United's IDD team to intervene in resolving issues if possible and, if not, to prepare and implement a discharge and/or transition plan as appropriate, including reasonable time to prepare the Covered Person and his/her parents or guardian for discharge or transfer;

v) Notify the Covered Person and/or the Covered Person's representative (if applicable) in writing prior to discharge in accordance with state and federal requirements, including involving the member and their family or legal guardian in planning for any transfer or discharge. This process must include providing a summary of the Covered Person's course of stay in the ICF/IID, a final summary of the Covered Person's developmental, behavioral, social, health and nutritional status, and include the current status of the objectives listed in the member's IPP as well as a post-discharge plan of care;

vi) Accept payment or appropriate denial made by United (or, if applicable, payment by United that is supplementary to the member's third party payer) plus the amount of any applicable Patient Liability, as payment in full for services provided and shall not solicit or accept any surety or guarantee of payment from a Covered Person in excess of the amount of applicable Patient Liability. For purposes of this Section 4.17(vi), Covered Person shall include the patient, parent(s), guardian, spouse or any other legally responsible person of the Covered Person being served;

vii) Ensure compliance regarding a Covered Person's Patient Liability as specified in sections A.2.6.7 and A.2.21.5 of the CRA, which shall include but not be limited to collecting the

applicable Covered Person Patient Liability amounts from CHOICES Group 1 members, notifying the Covered Person's Care Coordinator if there is an issue with collecting a Covered Person's Patient Liability, and making good faith efforts to collect payment;

viii) Provide timely certification and recertification (as applicable) of the Covered Person's level of care eligibility for ICF/IID services and level of need for and receipt of continuous active treatment, and cooperate fully with United in the completion and submission of the level of care assessment;

ix) Submit complete and accurate Pre-Admission Evaluation (PAE) that satisfy all technical requirements specified by TennCare, and accurately reflect the Covered Person's current medical and functional status. Provider shall also submit all supporting documentation required in the PAE and required pursuant to TennCare rules;

x) Notify United of any change in a Covered Person's medical or functional condition that could impact the Covered Person's level of care eligibility and level of need for and receipt of continuous active treatment;

xi) Comply with state and federal laws and regulations applicable to ICFs/IID as well as any applicable federal court orders, including but not limited to the American with Disabilities Act and those that govern admission, transfer, and discharge policies;

xii) Cooperate with United in developing and implementing protocols as part of United's ICF/IID diversion and transition plans pursuant to the Americans with Disabilities Act (see Section A.2.9.7.7), which shall, include, at a minimum, the ICF/IID's obligation to promptly notify United upon request for admission of an eligible Covered Person regardless of payor source for the ICF/IID stay; refusal of admission of any person to an ICF/IID for whom Medicaid reimbursement will be sought pending completion of a Community Informed Choice process as prescribed by TennCare, and approval of such admission by the State; how the ICF/IID will assist United in identifying current ICF/IID residents who may want to transition from ICF/IID services to home and community-based care; the ICF/IID's obligation to promptly notify United regarding all such identified members; and how the ICF/IID will work with United in assessing the Covered Person's transition potential and needs, and in developing and implementing a transition plan, pursuant to 42 C.F.R. 483.440;

xiii) Have on file a system designed and utilized to ensure the integrity of the Covered Person's personal financial resources. This system shall be designed in accordance with the regulations and guidelines set out by the Comptroller of the Treasury and the applicable federal regulations;

xiv) Immediately notify United of any change in its license to operate as issued DIDD as well as any deficiencies cited during the federal certification or licensure process;

SECTION 5
UNITED REQUIREMENTS

5.1 Prompt Payment. United shall pay Provider upon receipt of a clean claim properly submitted by Provider within the required time frames as specified in TCA 56-32-126 and section A.2.22.4 of the CRA as may be amended from time to time. Payments made via electronic transfers shall

include a signed ETF form that includes 42 CFR 455.18 and 455.19 statements immediately preceding the "Signature" section. United shall pay Provider only for services (1) provided in accordance with the requirements of the CRA, United's policies and procedures as set forth in the Agreement and this Appendix, and State and federal law and (2) provided to Covered Persons enrolled with United. Provider is responsible for (1) ensuring that any applicable authorization requirements are met and (2) verifying that a person is eligible for TennCare on the date of service.

5.2 Third Party Liability. 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 CRA. Provider shall identify third party liability coverage, including Medicare and long-term care insurance and if applicable, seek such third party liability payment before submitting claims to United. Unless United otherwise requests assistance from Provider, United will be responsible for third party collections in accordance with the terms of the CRA.

5.3 Alternate Claims Processing. In the event that the Division of TennCare deems United unable to timely process and reimburse claims and requires United to submit Provider claims for reimbursement to an alternative claims processor to ensure timely reimbursement, Provider shall agree to accept reimbursement at United's contracted reimbursement rate or the rate established by the Division of TennCare, whichever is greater.

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

5.5 Provider Discrimination Prohibition. United shall not discriminate with respect to participation, reimbursement, or indemnification of a provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification. United shall not discriminate against Provider for serving high-risk Covered Persons or if Provider specializes in conditions requiring costly treatments. This provision shall not be construed as prohibiting United from limiting a provider's participation to the extent necessary to meet the needs of Covered Persons. This provision also is not intended and shall not interfere with measures established by United that are designed to maintain quality of care practice standards and control costs. In addition, as a participant in a program receiving federal funds, providers shall not be subjected to discrimination because of their race, color, national origin, disability, age, sex, conscience and religious freedom, or other statuses protected by federal and/or state law.

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

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

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

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

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

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

5.7 Termination or Assignment of Agreement. In addition to its termination rights under the Agreement, United shall have the right to suspend, deny, refuse to renew or terminate the Agreement in accordance with the terms of the CRA section E.14 and applicable law and regulation.

To the extent applicable to Providers provision of Covered Services (as defined within this Appendix), the Agreement shall be assignable from United to the State, or its designee, at the State's discretion upon written notice to United and Provider. Further, Provider agrees to be bound by any such assignment, and the State, or its designee, shall not be responsible for past obligations of United.

5.8 Sanctions. United shall have the right to assess liquidated damages, sanctions, or reductions in payment for specific failures to comply with contractual or credentialing requirements. This shall include, but may not be limited to, Provider's failure or refusal to respond to United's request for information, request to provide Medical Records, or request to provide credentialing information. At United's discretion or a directive by TennCare, United shall impose financial penalties against Provider as appropriate. Such action shall be taken in accordance with the terms of the CRA and applicable law and regulation.

5.9 Provision of Materials to Provider. United will provide a copy of the applicable member handbook and Provider Manual to provider, and may do so via website at www.uhccommunityplan.com or other appropriate format.

5.10 Notice of Denied Authorizations. United will provide notice to Provider of any denied authorizations in accordance with the Provider Manual or other United policies and procedures.

5.11 Recoupment. United will not recoup payments made to Provider when the specific issue, services or claims that are the basis of the repayment are currently being investigated by TennCare or the State of Tennessee, are the subject of pending federal or State litigation, or are being audited by the TennCare Recovery Audit Contractor (RAC). United will seek permission from the Division of TennCare before initiating any recoupment of any program integrity related funds in compliance with section A.2.20.1.11 of the CRA, to ensure that the repayment is permissible. In the event United obtains funds in cases where repayment is prohibited, such funds shall be returned to Provider.

SECTION 6
OTHER REQUIREMENTS

6.1 Compliance with State Contract. All tasks performed under the Agreement shall be performed in accordance with the requirements of the applicable CRA, as set forth in this Appendix, the Provider Manual, and protocols, policies and procedures that United has provided or delivered to Provider. No other terms or conditions agreed to by United and Provider shall negate or supersede the requirements of section A.2.12.9 or other applicable provisions of the CRA, which are

incorporated into the Agreement by reference. It is United's responsibility to provide all necessary training and information to Provider to ensure satisfaction of all United's responsibilities specified under the CRA. Nothing in the Agreement relieves United of its responsibility under the CRA. If the Division of TennCare determines any provision of the Agreement is in conflict with provisions of the applicable CRA, the terms of the CRA shall control and the terms of the Agreement in conflict with those of the CRA will be considered null and void. All other provisions of the Agreement shall remain in full force and effect.

6.2 Monitoring. United shall perform ongoing monitoring of Provider and shall perform periodic formal reviews, whether announced or unannounced, of Provider and of Covered Services rendered to Covered Persons, consistent with the requirements of State and federal law and the applicable CRA. As a result of such monitoring activities, United shall identify to Provider any deficiencies or areas for improvement mandated under the CRA and Provider shall take appropriate corrective action where necessary to improve quality of care, in accordance with that level of medical, behavioral health, or Long-Term Services and Supports which is recognized as acceptable professional practice in the respective community in which Provider practices and/or the standards established by the Division of TennCare. Provider shall comply with any corrective action plan initiated by United.

6.3 Delegation. The parties agree that, prior to execution of the Agreement, United evaluated Provider's ability to perform any duties delegated to Provider under the Agreement. Any delegated duties and reporting responsibilities shall be set forth in the Agreement or other written delegation agreement or addendum between the parties. United shall have the right to revoke any functions or activities United delegates to Provider under the Agreement if in United's reasonable judgment Provider's performance under the Agreement is inadequate.

6.4 Reassignment of Payment. Any assignment of TennCare funds or payments to billing agents or alternative payees and any reassignment of payment must be made in accordance with 42 CFR 447.10 and shall require an executed billing agent agreement or alternative payee assignment agreement. If the alternative payee assignment is on-going, United or Provider, as applicable, shall screen the billing agents and alternative payees initially and monthly through the federal exclusion (LEIE), TennCare's Terminated Provider List, and debarment (EPLS/SAM) databases. Any direct or indirect payments to out of country individuals and/or entities are prohibited.

6.5 Entire Agreement. The Agreement, including the appendices, Provider Manual and policies and procedures referenced in, and incorporated into, the Agreement and this Appendix contain the entire agreement of United and Provider, and shall supersede all other oral agreements or negotiations between the parties. The Agreement, and any renewal of the Agreement, shall include a signature page which contains United's and Provider's names which are typed or legibly written, Provider's company with titles, and dated signatures of all appropriate parties and specify the effective date.

6.6 Amendment. This Agreement may be amended at any time by mutual agreement of the parties, provided that before any amendment shall be operative and valid, it shall be reduced to writing and signed by United and Provider and be attached to the Agreement. The only exception will be changes required to conform the contract to regulatory requirements required by the State of Tennessee as described in Section 1 of this Appendix. All notification of amended language will be documented (e.g., Certified Mail, facsimile, hand-delivered receipt, etc.). Provider shall have thirty (30) days from the date that United sends notice of change to give notice of rejection. Notice of rejection shall constitute termination without cause and require Provider to follow the termination provisions outlined in the Agreement.

6.7 State Review and Approval. The Agreement and this Appendix, and any future revisions to the Agreement or this Appendix, are subject to advance approval of TDCI in accordance with applicable State law regarding the approval of a certificate of authority (COA) and any material modifications thereof. United shall revise the Agreement and this Appendix as directed by the Division of TennCare. Further, the Division of TennCare shall have the right to direct United to terminate or modify the Agreement when the Division of TennCare determines it to be in the best interest of the State.

6.8 Termination of CRA. United and Provider recognize and agree that in the event of termination of an applicable CRA, Provider shall immediately make available to the Division of TennCare, or its designated representative, in a usable form, any or all records, whether medical or financial, related to Provider's activities undertaken pursuant to the Agreement. The provision of such records shall be at no expense to the Division of TennCare. Provider shall continue to provide Covered Services under the terms and conditions of the Agreement for up to forty-five (45) calendar days from the termination date or until Covered Persons can be transferred to another managed care organization, whichever is longer. United shall continue to reimburse Provider for Covered Services through the end of United's obligations under the CRA.

6.9 Governing Law. The parties acknowledge that any disputes arising out of TennCare program services or items provided pursuant to the CRA shall be governed by and construed in accordance with the law of the State of Tennessee.

6.10 Escalators. As provided at Section 2.13.2.2 in the CRA between United and TennCare, the parties agree that United shall not reimburse Provider based on automatic escalators or linkages to other methodologies that escalate such as current Medicare rates or inflation indexes unless otherwise allowed by TennCare.

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