ADDENDUM A

VIRGINIA MEDICAID COMPLIANCE ADDENDUM – PROVIDER

This Medicaid Compliance Addendum is incorporated by reference in the Agreement. If there is any conflict between the terms of this Addendum and any of the terms of the Agreement, including any attachments, schedules, exhibits and/or addenda made part of the Agreement, the terms of this Addendum shall govern and control; provided, however, that if there is any conflict between any of the terms of the Agreement, including this Addendum, and the Cardinal Care Contract between Company and the Virginia Department of Medical Assistance Services' ("DMAS" or the "Department"), [DATE], as amended or superseded (the "Contract"), then the terms of the Contract will govern and control.

For purposes of this Addendum, the term "Provider" shall mean the health care provider, or physician, group, facility, or hospital executing the Agreement, as identified on the first page of the Agreement. In the event that any of the following required Medicaid provisions are inapplicable to Provider, as construed under the Contract and in accordance with Applicable Law, such provision shall not apply.

Company and Provider agree to abide by all applicable provisions of the Contract. Provider compliance with the Contract specifically includes, but is not limited to, the requirements contained herein.

1.0 DEFINITIONS

All capitalized terms used in this Addendum, and not otherwise defined in this Addendum, shall have the meanings set forth in the Agreement, or if not defined in the Agreement, in the Contract.

2.0 REGULATORY AND CONTRACTUAL REQUIREMENTS

2.1 Duty to Refund. Provider shall refund payments made by Company if Provider is found to have billed Company contrary to policy, failed to maintain records or adequate documentation to support its claims, or billed for medically unnecessary services. (*12VAC30-120-1720(A)(4); 12VAC30-141-650(D); and 12VAC30-141-870(D) and Cardinal Contract, Section 5.12.5.10, 5.12.5.11*)

2.2 Agreement Subject to Department Review. Provider acknowledges and agrees that the Department may approve, modify and approve, or deny the Agreement and any changes in approved agreements at its sole discretion. Provider further acknowledges and agrees that the Department, at its sole discretion, may impose such conditions or limitations on its approval of the Agreement or changes to approved agreements as it deems appropriate. Provider shall cooperate with Company in Company's submission to the Department of the Agreement for initial approval and, if necessary, approval of any future changes. (*Cardinal Contract, Section 7.3.6*)

2.3 Validity of Terms. No terms of the Agreement are valid which terminate legal liability of Company in the Contract. (*Cardinal Contract, Attachment C, "Network Provider Agreement Prohibitions," at 1.*)

2.4 Provider Cooperation with Company Programs. Provider agrees to participate in and contribute required data to Company's quality improvement and other assurance programs as required in the Contract. Provider agrees to cooperate with the External Quality Review Organization (EQRO), which is contracted by the Department to perform quality studies. The level of cooperation includes, but is not limited to, responding favorably and promptly to requests for Members' medical records in the format and timeframe requested by the EQRO or the Department. (*Cardinal Contract, Section 10 and Attachment C.12, 13*)

2.5 Emergency and Urgent Care. Provider agrees to abide by the terms of the Contract for the timely provision of emergency and urgent care. Where applicable, Provider agrees to follow those procedures for handling urgent and emergency care cases stipulated in any required hospital/emergency department Memorandums of Understanding signed by Company in accordance with the Contract. (*Cardinal Contract, Section 5.7.1, 7.2.3, 12.1, Attachment C.14*)

2.6 Utilization Data. Provider agrees to submit to Company utilization data in the format specified by Company, so Company can meet the Department specifications required by the Contract. (*Cardinal Contract, Section 6.1.5, 8.11*)

2.7 Conflicts. Any conflict in the interpretation of Company's Policies or the Agreement shall be resolved in

accordance with Federal and Virginia laws and regulations, including the State Plan for Medical Assistance Services and Department memos, notices, and provider manuals. (*Cardinal Contract, Section 1.1*)

2.8 Non-discrimination. Provider agrees to comply with all non-discrimination requirements in the Contract relating to equal employment opportunity and accessibility of services. Provider shall provide services to members under the Contract in the same manner as it provides those services to all non-Medicaid and non-FAMIS members, including those with limited English proficiency or physical or mental disabilities. Provider shall offer hours of operation that are no less than the hours of operation offered to commercial members or other Virginia Medicaid programs, if Provider serves only Medicaid and/or FAMIS members. (*Cardinal Contract, Section 2.5, 2.14, 21.1.3*)

2.9 Record Retention. Provider agrees to comply with all record retention requirements and, where applicable, the special reporting requirements on sterilizations and hysterectomies stipulated in the Contract. Specifically, Provider agrees to retain, as applicable, enrollee grievance and appeal records in accordance with 42 CFR § 438.416, base data in 42 CFR § 438.5(c), MLR reports in 42 CFR § 438.8(k), and the data, information, and documentation specified in 42 CFR §§ 438.604, 438.606, 438.608, and 438.610 for a period of no less than 10 years after final payment is made under the Agreement or, in the event that the Agreement is renewed, 10 years after the renewal date or, if applicable, the resolution of an audit, litigation, or other action involving such records; and further agrees to comply with HIPAA security and confidentiality of records standards as detailed in the Contract. (*Cardinal Contract, Section 11.16, 21.2.2 and Attachment C.5*)

2.10 Maintenance of Records. Provider agrees to comply with the requirements for maintenance and transfer of medical records stipulated in the Contract and all Applicable Laws. Provider agrees to make medical records available to members and their authorized representatives within ten (10) business days of the record request. (*12VAC5-408-210(A) and (B); Cardinal Contract, Section 4.1 and Attachment C.8; FAMIS Regulations, 12VAC30-141-650(B) and 12VAC30- 141-870(B)*)

2.11 Access to Facilities and Records.

2.11.1 Provider agrees to provide representatives of Company, as well as duly authorized agents or representatives of the Department, the U.S. Department of Health and Human Services, and the State Medicaid Fraud Control Unit access to its premises and its books, fee schedules, documents, papers, records, contracts and/or medical records in accordance with the Contract. Provider must allow the Department, or its duly authorized representatives to inspect, copy, and audit any of Provider's medical and/or financial records. Provider agrees otherwise to preserve the full confidentiality of medical records in accordance with the Contract. Provider must forward to Company medical records within ten (10) business days of Company's request. (*FAMIS Regulations, 12VAC30-141-650(C) and 12VAC30-141-870(C); Cardinal Contract, Section 17.3.2, 21.2.1, 21.2.2 and Attachment C.7*)

2.11.2 Provider shall allow duly authorized agents or representatives of the State or Federal Government, at any time, access to its premises to inspect, audit, monitor or otherwise evaluate the performance of Provider's contractual activities and shall forthwith produce all records requested as part of such review or audit. Duly authorized agents or representatives of the State or Federal Government shall have the right to audit and inspect any books or record of Provider pertaining to the ability of Provider to bear the risk of financial losses and services performed or payable amounts under the Contract. In the event right of access is requested, Provider shall, upon request, provide and make available staff to assist in the audit or inspection effort, and provide adequate space on the premises to reasonably accommodate the State or Federal personnel conducting the audit or inspection effort. All inspections or audits shall be conducted in a manner as will not unduly interfere with the performance of Provider's activities. All information so obtained will be accorded confidential treatment as provided under Applicable Law. Provider agrees that the terms of this provision extend to its subcontractors and network providers, as applicable. (*Cardinal Contract, Section 21.2.1, 21.2.2 and Attachment C.7*)

2.12 Member Access to Records. Provider agrees to the requirements for maintenance and transfer of medical records stipulated in the Contract. Provider further agrees to make medical records available to Members and their authorized representatives within ten (10) business days of the record request. (*Cardinal Contract, Attachment C.9*)

2.13 Provider Disclosures. Provider agrees to disclose the required information, at the time of application, credentialing, and/or recredentialing, and/or upon request, in accordance with 42 CFR Part 455, Subpart B, and relevant provisions of the Contract, as related to ownership and control, business transactions, and criminal conviction for offenses against Federally related health care programs including Medicare, Medicaid, or CHIP programs. See 42

CFR §§ 455.101 - 455.106 for definitions, percentage calculations, and requirements for disclosure of ownership, business transactions, and information on persons convicted of crimes related to any Federal health care programs. (*Cardinal Contract, Attachment C.10*)

2.14 Confidentiality of Family Planning Services. Provider agrees to ensure confidentiality of family planning services in accordance with the Contract, except to the extent required by law, including, but not limited to, the Virginia Freedom of Information Act. (*Cardinal Contract, Attachment C.6*)

2.15 No Barriers to Care. Provider agrees to not create barriers to access to care by imposing requirements upon Members that are inconsistent with the provision of Medically Necessary and covered Medicaid/FAMIS services. (*Cardinal Contract, Attachment C.15*)

2.16 Provider Referrals and Hold Harmless. Provider agrees to clearly specify referral approval requirements to its providers and in any sub-subcontracts. Additionally, Provider hereby agrees that, if there is an intermediary organization between Company and Provider, the hold harmless requirement set forth in Section 13.3 of the Contract shall include nonpayment by the Plan, Company, and the intermediary organization. Provider further agrees that the hold harmless requirement applies in circumstances where Provider fails to obtain necessary referrals, preauthorization, or fails to perform other required administrative functions. (*Virginia Code § 38.2- 5805(C)(10)*; *Cardinal Contract, Section 8.9.4, 13.3, 14.3; Attachment C.21*)

2.17 Restriction on Billing Members. Provider agrees not to bill Medicaid Members for medically necessary services covered under the Contract and provided during the Member's period of enrollment, including coinsurance, copayments, deductibles, financial penalties, or any other amount, other than for any Patient Pay established by Department of Social Services (DSS) towards long term services and supports (LTSS) services. This provision shall continue to be in effect even if Company becomes insolvent. Provider shall hold members harmless for charges for any Medicaid covered service. This includes those circumstances where Provider fails to obtain necessary referrals, preauthorization, or fails to perform other required administrative functions. However, if a Member agrees in advance of receiving the service and in writing to pay for a service that is not a State Plan service, then Provider can bill the Member for the service. (*Cardinal Care Section 13.3; Attachment C.23*)

2.18 Prompt Provision of Covered Services. Provider shall promptly provide or arrange for the provision of all services required under the Agreement. This provision shall continue to be in effect for subcontract periods for which payment has been made even if Provider becomes insolvent until such time as Members are withdrawn from assignment to Provider. (*Cardinal Contract, Attachment C.18*)

2.19 PCP Obligation to Continue Services after Disenrollment. Except in the case of death or illness, Provider, if serving as a PCP, agrees to notify Company at least thirty (30) days in advance of disenrollment and agrees to continue care for his or her panel Members for up to thirty (30) days after such notification, until another PCP is chosen or assigned. (*Cardinal Contract, Attachment C.16*)

2.20 PCP Panel. Providers serving as a PCP pursuant to the Agreement agree to act as a PCP for the predetermined number of Members set forth on the PCP Panel Schedule attached hereto, not to exceed the panel size limits set forth in the Contract. (*Cardinal Contract, Attachment C.17*)

2.21 Timeframe for Payment. Company agrees to pay Provider within thirty (30) days of the receipt of a claim for Covered Services rendered to a covered Member unless there is a signed agreement with Provider that states another timeframe for payment that is acceptable to Provider. (*Cardinal Contract, Section 12.2.4 and Attachment C.26*)

2.22 Prior Authorization Procedures. Company shall follow prior authorization procedures pursuant to the *Code of Virginia* § 38.2-3407.15:2, which are hereby incorporated by reference. Company must accept telephonic, facsimile, or electronic submissions of prior authorization requests that are delivered from e-prescribing systems, electronic health records, and health information exchange platforms that utilize the National Council for Prescription Drug Programs' SCRIPT standards for prior authorization requests. (*Cardinal Contract, Attachment C.20*)

2.23 State Appropriations. Notwithstanding any other provision to the contrary, the obligations of Virginia shall be limited to annual appropriations by its governing body for the purposes of the subcontract. (*Cardinal Contract,*

Section 21.1.20)

2.24 Confidentiality of Medical Records. Provider shall comply with the security and confidentiality of medical records standards as detailed in the Contract. Specifically, for all referrals that require the sharing of a Member's medical information, Provider shall obtain necessary written and signed informed consent from Member prior to release of Member's medical information. All requests for medical information shall be consistent with the confidentiality requirements of 42 CFR Part 431, Subpart F. (*Cardinal Contract, Section 11.7*)

2.25 Member Rights. Provider shall comply with any Applicable Laws that pertain to member rights. (*Cardinal Contract, Section 4.1*)

2.26 Emergency Services (Hospitals Only). In accordance with Section 1867 of the Social Security Act, if Provider is a hospital that offers Emergency Services, Provider shall perform a medical screening examination on all people who come to Provider seeking emergency care, regardless of their insurance status or other personal characteristics. If an Emergency Medical Condition is found to exist, Provider must provide whatever treatment is necessary to stabilize that condition. Provider may not transfer a patient in an unstabilized emergency condition to another facility unless the medical benefits of the transfer outweigh the risks, and the transfer conforms to all applicable requirements. (*Cardinal Contract, Section 5.7*)

2.27 Immunization Registry Database. To the extent possible, and as permitted by Virginia statute and regulations, Provider shall participate in the state-wide immunization registry database. (*Cardinal Contract, Section 5.8.6*)

2.28 Members with Disabilities. Provider must ensure that Members with disabilities have effective communication with health care system participants in making decisions with respect to treatment options. (*Cardinal Contract, Section 4.3.2, 4.3.7, 8.9.1.2.6*)

2.29 Maternity Care. Provider shall screen pregnant women (or refer to an appropriate practitioner to screen) for maternal mental health concerns including but not limited to postpartum depression in accordance with the American College of Obstetricians and Gynecologists (ACOG) or American Academy of Pediatrics (AAP) standards. (*Cardinal Contract, Section 5.13.1.3, 8.9.1.3*)

2.30 Provider Appeals. Provider has the right to appeal adverse decisions to the Department. If Provider has rendered services to a member enrolled with Company in the Medicaid program and has either been denied authorization/reimbursement for the services or has received reduced authorization/reimbursement, Provider can request a reconsideration of the denied or reduced authorization/reimbursement. Before appealing to the Department, Provider must first exhaust Company's internal appeals and reconsideration processes as set forth in the Agreement and Contract. (*Cardinal Contract, Section 9.8*)

2.31 Provider Identifiers. In accordance with requirements set forth in 1932(d)(4) and 1173(b)(2) of the Social Security Act, Company shall assign a unique identifier to Provider, and Provider shall use this identifier when submitting data to Company. (*Cardinal Contract, Section 11 and Attachment C.2*)

2.32 Provider Bankruptcy. Provider shall notify Company of any bankruptcy filing on or before the date of such filing. (*Cardinal Contract, Section 21.2.40.4*)

2.33 Credentialing of Behavioral Health Providers. To the extent that Provider provides Community Based Mental Health Services (CBMHS) or Addiction and Recovery Treatment Services (ARTS), Provider must meet any applicable Department of Behavioral Health and Developmental Services (DBHDS) certification and licensing standards. Behavioral health and ARTS providers also shall meet Department's qualifications as outlined in 12 VAC 30-130-5000, et al., and Department's most current behavioral health provider manuals, including the community mental health rehabilitative services, mental health clinic, and psychiatric services provider manuals found at: https://vamedicaid.dmas.virginia.gov/manuals/provider-manuals-library. (*Cardinal Contract, Section 7.3.4*)

2.34 Excluded Entities/Service Providers. Provider shall screen its employees and contractors initially and on an ongoing monthly basis against the HHS-OIG online exclusions database to determine whether any of its employees/contractors have been excluded from participation in Federal health care programs (as defined in Section

1128B(f) of the Social Security Act) and not employ or contract with an individual or entity that has been excluded or debarred. The HHS-OIG online exclusions database is available at https://exclusions.oig.hhs.gov/. Provider shall immediately report to Company any exclusion information discovered. Provider is further prohibited from contracting with providers who have been terminated from the Medicaid program by the Department for fraud, waste, and abuse. (*Cardinal Contract, Section 7.3.8*)

2.35 Provider Payment Processing. Company shall pay community behavioral health, early intervention, and ARTS providers no less than the current Medicaid Fee For Service rate or a different negotiated rate as mutually agreed upon by Provider and Company and outlined in the Agreement. (*Cardinal Contract, Section 8.11.5, 8.12.4, 12.2.4*)

2.36 Early Intervention Services. To the extent that Provider provides Early Intervention Services, Provider must adhere to the requirements and provide services in accordance with Virginia and Federal laws and regulations governing the provision of Early Intervention Services, as well as both of the Early Intervention Practice Manuals (DMAS and DBHDS Part C). (*Cardinal Contract, Section 5.9, 5.13.3.5, 7.3.5.3, 12.2.4*)

2.37 Screenings (Under EPSDT). To the extent that Provider is a pediatric primary care provider, Provider shall incorporate the use of a standardized developmental screening tool for children consistent with the American Academy of Pediatrics (AAP) policy statements and clinical guidelines. AAP policy recommends surveillance (assessing for risk) at all well-child visits, and screening using a standardized tool routinely. Developmental screenings must be documented in the medical record using a standardized screening tool. (*Cardinal Contract, Section 5.8.3*)

2.38 HIPAA Disclaimer. To the extent that Provider renders services under the Contract on behalf of Company, and Provider receives or has access to PHI, Provider agrees to sign an agreement with Company that complies with HIPAA and to be bound by the same restrictions, terms, and conditions relating to PHI that apply to Company under the Contract. Provider specifically agrees to report breaches of PHI to Company on the same day Provider discovers such breach. (*Cardinal Contract, Section 21.2.6*)

2.39 Overpayments. Provider shall promptly report any overpayments to Company and shall return overpayments to Company in accordance with Company policy within sixty (60) calendar days after the date on which the overpayment was identified. Provider also shall notify Company in writing of the reason for the overpayment in accordance with 42 C.F.R. § 438.608(d)(2). (*Cardinal Contract, Section 19.1*)

2.40 Provider-Preventable Conditions. Provider shall comply with 42 CFR § 438.3(g) requirements mandating provider identification of provider-preventable conditions as a condition of payment. Company shall not agree to a payment methodology which would pay for provider-preventable conditions as set forth in 42 C.F.R. § 434.6(a)(12) and 42 C.F.R. § 447.26. (*Cardinal Contract, Section 12.1.1 and Attachment C.27*)

2.41 Network Provider Contract Supplement (Provider Manual). A Provider Manual may be used to supplement the Agreement. The Provider Manual, including any amendments and revisions, is incorporated into Provider's obligations under the Agreement by this reference. It is understood that the Agreement takes precedence over any language in the Provider Manual. (*Cardinal Contract, Attachment C*)

3.0 STATUTORY AND REGULATORY REQUIREMENTS FOR MANAGED CARE PLANS

3.1 Health Care Provider Panels.

3.1.1 For a period of at least 90 days from the date of the notice of Provider's termination from Company's provider panel, except when Provider is terminated for cause, Provider shall be permitted by Company to render health care services to any Members who were in an active course of treatment from Provider prior to the notice of termination and request to continue receiving health care services from Provider. (*Virginia Code § 38.2-3407.10(F)(1)*)

3.1.2 Notwithstanding the provisions of 3.1.1, Provider shall be permitted to continue rendering health services to any Member who has entered the second trimester of pregnancy at the time of Provider's termination of participation, except when Provider is terminated for cause. Such treatment shall, at the Member's option, continue through the provision of postpartum care directly related to the delivery. (*Virginia Code §38.2-3407.10(F)(2)*)

3.1.3 Notwithstanding the provisions of 3.1.1, Provider shall be permitted to continue rendering health services to any Member who is determined to be terminally ill (as defined under § 1861 (dd)(3)(A) of the Social Security Act) at the time of Provider's termination of participation, except when Provider is terminated for cause. Such treatment shall, at the Member's option, continue for the remainder of the Member's life for care directly related to the treatment of the terminal illness. (*Virginia Code § 38.2-3407.10(F)(3)*)

3.2 Medically Necessary Services. Nothing contained in this Addendum or in the Agreement shall be construed to require Provider to deny Covered Services that Provider knows to be Medically Necessary and appropriate that are provided with respect to a specific Member or group of Members with similar medical conditions. (*Virginia Code § 38.2-3407(N)*)

3.3 Limitation on Remedies. None of Provider, its agents, trustees, or assignees may maintain any action at law against a Member to collect sums owed by Company or any intermediary organization between Company and Provider. (*Virginia Code § 38.2-5805(C)(2) and (5)*)

3.4 Urgent Care and Emergency Services. Provider shall allow its Members, on a 24-hour basis, (i) access to medical care or (ii) access by telephone to a physician or licensed health care professional with appropriate medical training who can refer or direct a Member for prompt medical care in cases where there is a need for urgent care or Emergency Services. Provider shall clearly notify Members of provisions for urgent care or Emergency Services when Provider is not available after hours. (*12VAC5-408-280(A) and (C)*)

4.0 REGULATORY REQUIREMENTS SPECIFIC TO MEDALLION MANDATORY MANAGED CARE

4.1 Compliance with Quality of Care Standards. Provider shall comply, and cause its employees, agents, independent contractors, and subcontractors to comply, with all applicable federal and state mandates, community standards for quality of care, and standards developed pursuant to the DMAS managed care quality program. (*12VAC30-120-380(E)*)

4.2 Cost-Sharing. In accordance with 42 CFR § 447.50 through 42 CFR § 447.60, no provision contained in this Addendum or in the Agreement shall be construed to impose any cost sharing obligations on Members except as set forth in 12VAC30-20-150 and 12VAC30-20-160. (*12VAC30-120-380(I)*)

5.0 COMMONWEALTH COORDINATED CARE PLUS REQUIREMENTS

5.1 Coverage Responsibility for Behavioral Health Services. To the extent that Provider provides behavioral health services and Addiction and Recovery Treatment Services (ARTS), Provider must meet Department's qualifications as outlined in 12VAC30-50-226, 12VAC30-60-143, 12VAC30-50-130 and 12VAC30-60-61. ARTS providers shall meet the requirements in 12VAC30-130-5000, et al., and the Department's most current behavioral health provider manuals, including the ARTS, community mental health rehabilitative services, mental health clinic, and psychiatric services provider manuals published on the DMAS website and currently found at https://vamedicaid.dmas.virginia.gov/manuals/provider-manuals-library. Community Based Mental Health and ARTS providers (public and private) shall meet any applicable Department of Behavioral Health and Developmental Services (DBHDS) certification and licensure standards. (*Cardinal Contract, Section 5.5.2, 5.5.6*)

5.2 Behavioral Health Services Outcomes. To the extent that Provider provides behavioral health services, Provider must collect clinical outcomes data as determined by Company and approved by the Department. Provider also must make available behavioral health clinical assessment, treatment planning, and outcomes data for quality, utilization, and network management purposes. (*Cardinal Contract, Section 10.7.1*)

5.3 Community Mental Health Services. To the extent that Provider provides Community Mental Health Services (CMHS), Provider must perform the required intake as defined in 12VAC30-50-226 prior to submitting a request for CMHS. (*Cardinal Contract, Section 5.5.2*)

5.4 Addiction and Recovery Treatment Services. To the extent that Provider provides ARTS services, Provider shall comply with the following requirements:

5.4.1 Program Integrity Safeguards. Provider shall cooperate with Company in fulfilling Company's obligation to perform an annual review of Provider to assure that the health care professionals under contract or other agreement with Provider are qualified to provide ARTS and that services are being provided in accordance with the Agreement, the American Society for Addiction Medicine (ASAM) criteria, and CCC Plus program requirements. (*Cardinal Contract, Section 7.3.5.2*)

5.4.2 Community Integration. Provider shall provide ARTS services in a manner that demonstrates cultural and linguistic competency as detailed in the Contract. (*Cardinal Contract, Section 2.16, 5.5.6.4*)

5.4.3 Services for Adolescents and Youth with Substance Use Disorders (SUD). Provider shall not work with children under age 21 unless Provider has experience in addiction treatment with children and adolescents. (*Cardinal Contract, Section 5.8.11*)

5.5 Early Intervention Services. To the extent that Provider provides Early Intervention services:

5.5.1 Provider must be contracted with or have a memorandum of agreement (MOA) in place with the local lead agency for the catchment area in which the Member resides. (*Cardinal Contract, Section 7.3.5.3*)

5.5.2 In accordance with 12VAC30-50-131, Provider must be certified by DBHDS to provide Early Intervention services. Providers of Early Intervention Care Management/Service Coordination must be certified through DBHDS as an Early Intervention Service Coordinator. (*Cardinal Contract, Section 7.3.5.3*)

5.6 Patient Pay for Long Term Services and Supports. Patient Pay refers to the Member's obligation to pay towards the cost of long-term services and supports ("LTSS") if the Member's income exceeds certain thresholds. The Patient Pay must not be confused with a co-pay or deductible. Company shall develop policies and procedures regarding the collection of the Patient Pay obligation. Company may collect it directly from the Member or assign this responsibility to Provider, to the extent that Provider provides LTSS. If assigned to Provider, Provider shall comply with Company's policies and procedures regarding the Patient Pay obligation, and Company shall reduce reimbursements to Provider equal to the Patient Pay obligation each month. (*Cardinal Contract, Section 5.12, 13.2.1*)

5.7 Special Rules Related to Financial Eligibility for Long Term Care. To the extent that Provider provides LTSS, Provider is allowed to bill the Member for certain non-covered services if Provider has informed the Member prior to LTSS admission that, if the Member is found by DSS to not be financially eligible for Medicaid funded long term services, the Member will be held financially liable for the costs of long-term services. (*Cardinal Contract, Section 5.12.4.2*)

5.8 Credentialing of CCC Plus Waiver Providers. Provider shall comply with the provider requirements as established in the DMAS provider manuals published on the DMAS website and currently found at https://vamedicaid.dmas.virginia.gov/manuals/provider-manuals-library and the following regulations: Elderly or Disabled with Consumer Directions (EDCD) Waiver – 12VAC30-120-900 through 12VAC30-120-995. All providers of CCC Plus Waiver services (including Adult Day Healthcare Center (ADHC)) shall maintain compliance with the provisions of the CMS Home and Community Based Settings Rule as detailed in 42 CFR § 441.301(c)(4)-(5) prior to executing a provider agreement. (*Cardinal Contract, Section 7.3.4 and Attachment C.3; 12VAC30-120-610 et seq.*)

5.9 Inpatient Admission Privileges. To the extent that Provider provides inpatient services to Members, Provider shall have admitting and treatment privileges in a minimum of one general acute care hospital. (*Cardinal Contract, Section 7.2.4*)

5.10 Critical Incidents. Provider shall report, respond to, and document critical incidents to Company in accordance with applicable requirements. "Critical incidents" shall include, but not be limited to, the following incidents: medication errors, severe injury or fall, theft; suspected physical or mental abuse or neglect; financial exploitation and death of a Member. The maximum timeframe for reporting an incident to Company shall be twenty-four (24) hours. The initial report of an incident within twenty-four (24) hours may be submitted verbally, in which case Provider shall submit a follow-up written report within forty-eight (48) hours. (*Cardinal Contract, Section 16.2*)

5.11 Prohibited Actions. Provider shall not knowingly have an employment, consulting, provider agreement, or other agreement or relationship for the provision of items and services that are significant and material to the Provider's

obligations under the Contract with any person, or affiliate of such person, who is excluded, under Federal law or regulation, from certain procurement and non-procurement activities. Further, no such person may have beneficial ownership of more than five (5) percent of Provider's equity or be permitted to serve as a director, officer, or partner of Provider. Provider is further prohibited from contracting with providers who have been terminated from the Medicaid program by the Department for fraud, waste, and abuse. Provider can screen managing employees, contractors, and other individuals against the HHS-OIG online exclusions database on a monthly basis to determine whether any such individuals have been excluded from participating in Federal health care programs. The HHS-OIG online exclusions database is available at https://exclusions.oig.hhs.gov/. Provider shall immediately report to Company any exclusion information discovered. (*Cardinal Contract, Section 12.1.5, 19.6.1*)

5.12 Protecting Member from Liability for Payment. Provider shall not deny any service covered under the Contract to a Member for failure or inability to pay any applicable charge or where Member, who, prior to becoming CCC Plus program eligible, incurred a bill that has not been paid. (*Cardinal Contract, Section 13.3*)

5.13 Immunizations/Vaccinations. To the extent that Provider provides EPSDT services, Provider shall comply with the following requirements:

5.13.1 Provider shall render immunizations, in accordance with the EPSDT periodicity schedule specified in the most current Advisory Committee on Immunization Practices (ACIP) Recommendation, concurrently with the EPSDT screening. Provider shall not inappropriately refer a Member to other providers for immunizations. (*Cardinal Contract, Section 5.8.3, 5.8.6*)

5.13.2 If Provider is a PCP who administers childhood immunizations, Provider shall be encouraged to enroll in the Virginia Vaccines for Children program (VVFC), administered by the Virginia Department of Health. (*Cardinal Contract, Section 5.8.6*)

5.13.3 If Provider is a PCP, Provider shall not be permitted to routinely refer Members to the local health department to receive vaccines. (*Cardinal Contract, Section 5.8.6*)

5.14 Clean Claim. Company shall pay Provider in accordance with the terms of the Contract upon receipt of a clean claim. A clean claim is a claim that has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payments from being made on the claim under this title. See Sections 1816(c)(2)(B) and 1842(c)(2)(B) of the Social Security Act. (*Cardinal Contract, Section 12.1*)

5.15 Medically Necessary or Medical Necessity. Per Virginia Medicaid, Medically Necessary or Medical Necessity is defined as an item or service provided for the diagnosis or treatment of an enrollee's condition consistent with standards of medical practice and in accordance with Virginia Medicaid policy (12 VAC 30-130-600) and EPSDT criteria (for those under age 21) and Federal regulations as defined in 42 CFR § 438.210 and 42 CFR § 440.230. (*Cardinal Contract, Section 22*)

5.16 Standard Contract Elements. Provider agrees to comply with the following requirements: (*Cardinal Contract, Section 7.3.6, 21.1.2, and Attachment C*)

5.16.1 Provider agrees to abide by all applicable provisions of the Contract.

5.16.2 Provider shall have a National Provider Identifier (NPI) number.

5.16.3 Provider shall meet Company's standards for licensure, certification, and credentialing.

5.16.4 Provider shall meet Company's standards for insurance coverage.

5.16.5 Provider shall comply with all applicable Federal and State laws and regulations, including Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; the Americans with Disabilities Act of 1990 as amended; Health Insurance Portability and Accountability Act of 1996 (HIPAA) security and privacy standards, section 1557 of the Patient Protection and Affordable Care Act (including, but not limited to, reporting

overpayments pursuant to state or federal law) and the Deficit Reduction Act of 2005 (DRA) requiring that emergency services be paid in accordance with the DRA provisions [Pub. L. No. 109-171, Section 6085], and as explained in CMS State Medicaid Director Letter SMDL #06-010. Provider shall maintain capacity to deliver services in a manner that accommodates the needs of its Members by: (*Cardinal Contract, Section 2.5*)

5.16.5.1 Providing flexibility in scheduling to accommodate the needs of Members;

5.16.5.2 Providing interpreters or translators for Members who are deaf and hard of hearing, and those who do not speak English;

5.16.5.3 Ensuring that individuals with disabilities are provided with reasonable accommodations to ensure effective communication, including auxiliary aids and services. Reasonable accommodations will depend on the particular needs of the individual and include but are not limited to:

5.16.5.3.1 Ensuring safe and appropriate physical access to buildings, services, and equipment;

5.16.5.3.2 Allowing extra time for Members to dress and undress, transfer to examination tables, and to understand the information provided by Provider so that Members can fully participate in the provision of care; and

5.16.5.3.3 Demonstrating compliance with the ADA by conducting an independent survey or site review of facilities for both physical, communication and programmatic accessibility, documenting any deficiencies in compliance and monitoring correction of deficiencies. (*Cardinal Contract, Section 7.2.12*)

5.16.6 Vehicles shall comply with the Americans with Disabilities Act specifications for transportation, 49 CFR Part 38, subparts A and B. (*Cardinal Contract, Section 7.2.12*)

5.16.7 Provider shall maintain records for ten (10) years from the close of the Provider Contract. For children under age twenty-one (21) enrolled in the CCC Plus Waiver, Provider shall retain records for the greater period of a minimum of ten (10) years or at least six (6) years after the minor has reached 21 years of age per 12VAC30-120- 1730. (*Cardinal Contract, Attachment C.5*)

5.16.8 Provider shall provide copies of Member records and access to its premises to representatives of Company, as well as duly authorized agents or representatives of the Department, the U.S. Department of Health and Human Services, and the State Medicaid Fraud Unit. (*Cardinal Contract, Section 17.3.2, 21.2.1 and Attachment C.7*)

5.16.9 Provider shall maintain and provide a copy of a Member's medical records, in accordance with 42 CFR § 438.208(b)(5), to the Member and his or her authorized representatives as required by Company and within no more than ten (10) days of the Member's request. (*Cardinal Contract, Attachment C.8*)

5.16.10 Provider shall screen its employees and contractors initially and on an ongoing monthly basis to determine whether any of its employees/contractors 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) and not employ or contract with an individual or entity that has been excluded or debarred. Provider shall immediately report to Company any exclusion information discovered. Provider is hereby informed that civil monetary penalties may be imposed against providers who employ or enter into contracts with excluded individuals or entities to provide items or services to CCC Plus Members. (*Cardinal Contract, Attachment C.11*)

5.16.11 Provider shall submit utilization data for Members in the format specified by Company, consistent with Company obligations to the Department as related to quality improvement and other assurance programs as required in the Contract. (*Cardinal Contract, Attachment C.12*)

5.16.12 Provider shall comply with corrective action plans initiated by Company. (*Cardinal Contract, Attachment C.19*)

5.16.13 Provider shall clearly specify referral approval requirements to its providers and in any sub-subcontracts. (*Cardinal Contract, Attachment C.21; 12VAC30-120-620*)

5.16.14 Provider shall hold Members harmless for charges for any Medicaid covered service. Provider shall accept Company payment as payment in full except for patient pay amounts and shall not bill or balance bill a Medicaid Member for Medicaid covered services provided during the Member's period of enrollment. The collection or receipt of any money, gift, donation, or other consideration from or on behalf of a CCC Plus recipient for any Medicaid covered service provided is expressly prohibited. This includes those circumstances where Provider fails to obtain necessary referrals, service authorization, or fails to perform other required administrative functions. (*Cardinal Contract, Section 13.5 and Attachment C.21*)

5.16.15 Should an audit by Company or an authorized state or federal official result in disallowance of amounts previously paid to Provider, Provider will reimburse Company upon demand. Provider shall not bill the Member in these instances. (*Cardinal Contract, Attachment C.22*)

5.16.16 Any conflict in the interpretation of Company's policies and the Agreement shall be resolved in accordance with Federal and Virginia laws and regulations, including the State Plan for Medical Assistance Services and Department memos, notices, and provider manuals. Provider shall comply with Federal contracting requirements described in 42 CFR § 438.3, including identification of/non-payment of provider-preventable conditions, conflict of interest safeguards, inspection and audit of records requirements, physician incentive plans, recordkeeping requirements, etc. (*Cardinal Contract, Attachment C.24*)

5.16.17 Provider shall comply with the claim processing and payment provisions as described in the Contract, Section 12.1, General Provider Payment Processes. (*Cardinal Contract, Section 12.1 and Attachment C.25*)

5.17 Special Provisions for Certain Provider Agreements. Provider agrees to comply with the following requirements, as applicable:

5.17.1 To the extent that Provider provides LTSS, ARTS, CMHS, or Early Intervention services, Provider shall use Department's established billing codes as described in the Cardinal Care Coverage Chart. (*Cardinal Contract, Attachment C, "Special Considerations for Certain Provider Agreements," at 1.*)

5.17.2 To the extent that Provider provides LTSS services, Provider shall comply with the CMS Federal Home and Community Based Services (HCBS) Settings Rule detailed in 42 C.F.R. § 441.301(c)(4)-(5). (*Cardinal Contract, Section 5.12.2.3, 7.1.6, 7.3.4.2, 8.6.1, 8.12.3 and Attachment C, "Special Considerations for Certain Provider Agreements," at 2*)

5.17.3 To the extent that Provider is a Nursing Facility or provides LTSS, ARTS, or Early Intervention services, Provider shall comply with the special claim processing and payment provisions as described in the Provider Payment Section of the Contract. (*Cardinal Contract, Attachment C, "Special Considerations for Certain Provider Agreements," at 3.*)

5.17.4 To the extent that Provider is a private provider of CMHS, Provider must be enrolled as an agency and bill with its agency NPI in accordance with the requirements found in the CMHS manual, Chapter 2. (*Cardinal Contract, Attachment C, "Special Considerations for Certain Provider Agreements," at 5.*)

5.17.5 To the extent that Provider is a Virginia Community Services Board (VCSB), Provider may bill under the facility NPI for qualifying practitioners in accordance with Department guidelines. Such guidelines apply to psychiatric services and CMHS as set forth in the Contract. (*Cardinal Contract, Attachment C, "Special Considerations for Certain Provider Agreements," at 5.a.*)

5.18 Special Provisions for Transportation Services. To the extent that Provider provides transportation services, Provider agrees to comply with the following requirements:

5.18.1 Driver Training. Provider acknowledges and agrees that all drivers who perform transports for CCC Plus Waiver enrolled Members, Members with dementia or cognitive impairments, or Members who require hand-to-hand or door-to-door level of assistance complete appropriate training prior to performing any trips for those levels of assistance. (*Cardinal Contract, Section 5.14.19*)

5.18.2 Attendants. The use of an attendant must be prior approved by Company, broker, or internal

transportation services. The transportation attendant can be an employee of a transportation provider, and/or Member's attendant, approved and reimbursed by Company, broker, or internal transportation services and is responsible for assisting the driver and accompanying a Member or group of Members during transport while ensuring safe operation of the vehicle and Members. (*Cardinal Contract, Section 5.14.15*)

5.19 Special Provisions for Non-Emergency Medical Transportation Services. To the extent that Provider provides non-emergency medical transportation (NEMT) services, Provider agrees to comply with the following requirements:

5.19.1 Driver, Attendant, and Vehicle Requirements. All vehicles and drivers must meet the requirements for training, licensing, vehicle inspection, registration, and insurance coverage as defined by the Department's fee-for-service NEMT program at http://www.dmas.virginia.gov/Content_pgs/trn-home.aspx. Further, all vehicles must meet or exceed applicable federal, state, and local requirements and manufacturer's safety, mechanical, operating, and maintenance standards while maintaining proof of compliance as to allow for unscheduled file audits. Company has the right and obligation to ensure that all vehicles transporting Members with disabilities comply with applicable requirements of the Americans with Disabilities Act (ADA), including the accessibility specifications for transportation vehicles. Provider shall cooperate with Company in fulfilling these obligations. (*Cardinal Contract, Section 5.14.9*)

5.19.2 Passenger Safety Requirements. Provider agrees to comply with the passenger safety requirements set forth in the Contract. (*Cardinal Contract, Section 5.14.14*)

5.19.3 Driver Trip Logs. Provider shall maintain trip logs in accordance with the Contract. The Department may audit the trip logs for compliance and completeness. (*Cardinal Contract, Section 5.14.22*)

5.20 Notification Obligations to Company and Department. Provider shall notify Company within thirty (30) days of any changes to a provider or subcontractor agreement regarding termination, pending termination, or pending modification in the subcontractor's or provider's terms that could reduce Member access to care. This written notice must occur in advance of the formal notification of termination from Company's or Provider's network. (*Cardinal Contract, Section 7.3.7.2*)

5.21 Prohibited Contract Elements. Nothing in the Agreement or in this Addendum shall be construed to: (*Cardinal Contract, Attachment C, "Network Provider Agreement Prohibitions."*)

5.21.1 Terminate legal liability of Company, Provider, or its providers and subcontractors in the Contract; or

5.21.2 Require as condition of participation or contracting in the CCC Plus program that Provider:

5.21.2.1 Shall not contract with other CCC Plus program contractors or Department's other managed care program contractors;

5.21.2.2 To the extent enrolled in Company's CCC Plus program network, also participate in Company's other lines of business (e.g., commercial managed care network). However, this provision does not preclude Company from requiring its other managed care (commercial, Medicare, etc.) network providers to participate in their CCC Plus program provider network; and

5.21.2.3 Abide by terms that limit Provider's participation with other CCC Plus program contractors.

5.21.3 Provide for or require indemnity to the extent that Provider is a state or local government entity.

5.22 Protection of Member-Provider Communications. Nothing in this Addendum or the Agreement shall prohibit or otherwise restrict Provider from advising a Member about his or her health status or medical care or treatment options for Member's condition or disease; information Member needs in order to decide among all relevant treatment options; risk, benefits and consequences of treatment or non-treatment; and/or Member's right to participate in decisions about his or her health care, including the right to refuse treatment and to express preferences about future

treatment decisions, regardless of whether benefits for such care or treatment are provided under the Contract, if Provider is acting within the lawful scope of practice. (*Cardinal Contract, Section 4.1.1*)

5.23 Exceptional Processing and Payment Rules.

5.23.1 Company and Provider shall comply with all exceptional processing and payment rules for Nursing Facilities, LTSS (including when LTSS services are covered under EPSDT), ARTS, CMHS, and Early Intervention in accordance with the Contract. Company may reimburse based on an alternative payment methodology or value-based payment if mutually agreed upon by Provider and Company. (*Cardinal Contract, Section 12.2.4*)

5.23.2 For all Members admitted to a nursing facility ("NF"), Company must not reimburse a NF prior to a LTSS screening completed for the Member in accordance with DMAS regulations and procedures by an appropriate screening team, the screening has been entered into the eMLS system, Company receives a copy of the screening, and the individual is found to meet NF level of care criteria. For Members admitted to a NF under one of the Special Circumstances identified in 12 VAC 30-60-302 who do not have a Medicaid LTSS screening, Company shall accept the MDS and may request the DMAS-80, Nursing Facility Admission, Discharge or Level of Care form. Following the Department's policy, Company must receive a copy of the LTSS screening package for Members admitted to a NF on or after July 1, 2019, prior to payment to a NF for that admission. For Members in a NF prior to July 1, 2019, in the event that a LTSS screening has not been completed, Company must accept the MDS to validate NF eligibility and may request the DMAS-80 form. (*Cardinal Contract, Section 12.2.4.1*)

5.24 Payment Suspension. Provider acknowledges and agrees that Company is required to suspend payments to Provider in the event that the Department has determined there to be a credible allegation of fraud against Provider. (*Cardinal Contract, Section 12.1.2*)

5.25 Company Right to Assess Claims of Fraud. Provider shall cooperate with Company in its process for assessing claims of fraudulent activity by Members and providers. Company may utilize, among other methods, computer software and periodic audits of medical records to perform such audits. (*Cardinal Contract, Section 18.3*)

5.26 Fraud and Abuse. Provider shall immediately and in no case later than in twenty-four (24) hours from the time of discovery report all incidents of potential or actual fraud, waste, and abuse to Company and to the Department. (*Cardinal Contract, Section 18.8*)

PCP Panel Schedule

(*Cardinal Contract, Attachment C.17*)

A Provider acting as a PCP shall accept new Members as patients until such Provider's panel consists of a minimum number of _____ Members.

Provider shall continue to accept new Members as otherwise required by the Agreement but may not exceed the panel size limits set forth in the Contract.