Capital Rx

Pharmacy Provider Manual

December 1, 2023 | V5

Introduction

Welcome to the Capital Rx pharmacy provider network(s). Capital Rx is a pharmacy benefit manager that manages the pharmacy benefits and provides other services including reporting and clinical management for a number of client Plan Sponsors and their Members. Capital Rx networks support both national and regional clients and is committed to fostering a strong relationship with its provider pharmacies.

Please review this Provider Manual thoroughly as it is intended to outline certain policies, procedures, and other instructions necessary for its provider pharmacies to follow for participation in the provider network(s) ("Networks"). This Provider Manual, along with the base Agreement (into which this Provider Manual is incorporated) and any related amendment(s), addendum(s), exhibit(s), or other applicable documentation, governs the relationship between Capital Rx and you, the pharmacy provider (including as applicable any of the pharmacy locations affiliated with your chain code(s)) (hereinafter, "You", "Your", or "Pharmacy").

Please note that this Provider Manual is subject to change by Capital Rx and such changes are effective at the time of publication. This Provider Manual is not intended to address every issue or replace sound clinical professional judgment.

Thank you for your participation in Capital Rx's Networks. We appreciate the role you play in ensuring the health and safety of our Members.

Relevant Contacts

Pharmacy Help Desk Services

For Member eligibility and benefit plan information, claims processing, and payment/remittance questions please contact us by dialing the number located on the back of the member's ID card or by calling 888-832-2779.

Hours of operation: 24 hours a day 7 days a week including holidays

For pharmacy payment related and pharmacy remittance advise questions, you may also reach out to provider_payments@cap-rx.com.

Capital Rx Provider Relations Department

If you have feedback, issues or questions you would like to share with Capital Rx including feedback related to quality of care or services, or have questions related to your Agreement or credentialing, please contact Capital Rx at the mailing address or email address below.

228 Park Ave S. Suite 87234
New York, NY 10003
Email: Provider.Relations@cap-rx.com

Provider Forms and Documents
Pharmacy forms and documents are available online at: https://www.cap-rx.com/providers/pharmacist

Capital Rx's formulary look-up tool is accessible online. This tool will enable you to search and determine if a medication is covered. This tool will also allow you to search for and identify utilization management edits, such as Prior Authorization, Quantity Limits, and Step Therapy. You can view the latest formulary updates by visiting our website at https://www.cap-rx.com/pharmacists. In the "Forms & Documents" section, the formularies can be accessed by selecting "Formulary Look-Up".

Pharmacy Notifications and Communications
Capital Rx provides notifications and communications to its network pharmacies regarding updates to procedures, payer sheets, formularies, Manual, etc. via email. Pharmacies are required to update their information directly with NCPDP. Maintaining information about your pharmacy in NCPDP is vital.

To request copies of previous pharmacy communications, please contact Capital Rx Provider Relations at the following: **Email:** Provider.Relations@cap-rx.com

Pharmacy Audit Communications
In the event Pharmacy needs to contact the Capital Rx Audit Department, please contact Capital Rx at the mailing address or email address below.

228 Park Ave S. Suite 87234
New York, NY 10003
Email: Pharmacy_audit@cap-rx.com

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I. Definitions

The following definitions may be used in this Provider Manual and are derived from definitions in the Agreement, Plan Sponsor requirements, or applicable law or regulations.

1) **"Agreement"** means the contractual agreement to which Pharmacy and Capital Rx are parties that governs their relationship.
2) **"Affiliate"** means with respect to any person or entity, any other person or entity which directly or indirectly controls, is controlled by or is under common control with such person or entity.
3) **"Average Wholesale Price" or "AWP"** means the benchmark price established by a nationally available reporting service as selected by PBM based on the 11-digit National Drug Code ("NDC") of the Covered Medication dispensed by Pharmacy.
4) **"Brand Drug Product"** means a drug that is either a Multi- Source Brand or a Single-Source Brand.
5) **"Capital Rx"** shall mean Capital Rx, Inc. and Capital Rx IPA, LLC.
6) **"Centers for Medicare & Medicaid Services (CMS)"** is a federal agency within the United States Department of Health & Human Services (HHS) that administers the Medicare program and works in partnership with state governments to administer Medicaid, the State Children's Health Insurance Program (SCHIP), and health insurance portability standards in addition to other responsibilities such as managing the administrative simplification standards from the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
7) **"Claim"** means and refers to Pharmacy's billing or invoicing following NCPDP standards for a single prescription for Covered Prescription Services dispensed to a Member enrolled with a Plan in accordance with the Agreement and this Provider Manual.
8) **"Claims Processor"** means Capital Rx or a third-party pharmacy claims processor with which Capital Rx may contract.
9) **"Clean Claim"** means and refers to a Claim prepared in the standard format promulgated by NCPDP which contains all of the information necessary for claim processing, that is compliant with all applicable legal requirements and regulations and it not found to be false, fraudulent, discrepant or otherwise ineligible by Capital Rx.
10) **"Co-payment" or "Cost Sharing Amount(s)"** means the amount Pharmacy shall collect from a Member for providing a Covered Prescription Service in accordance with the Member's Plan.
11) **"Compound Prescription"** means a prescription consisting of two or more ingredients, at least one of which is a prescription drug, and which is prepared by the pharmacist specifically for the Member according to the prescriber's directions. For the avoidance of doubt, the addition of only water and/or flavoring does not result in a Compound Prescription.
12) **"Covered Prescription Service(s)"** means the prescriptions and other products and services that may be dispensed or provided by Pharmacy to which a Member is entitled to receive in accordance with and subject to the terms and conditions of the Plan.
13) **"DAW 5 Claim"** means a Claim that is submitted with a dispense as written (DAW) code of 5, which indicates that a branded pharmaceutical product was dispensed in the same manner as a generic.
14) **"Dispensing Fee" means the agreed upon rates related to dispensing that Capital Rx has agreed to pay Pharmacy for the provisions of Covered Prescription Services to a Member.**
15) **"Drug"** means a pharmaceutical or pharmaceutical compound. This includes, without limitation, all products with a Medi-Span GPI-2 distinct from 97 or 94.
16) **"ePrescription"** means a prescription which is written and signed by a prescriber electronically and then transmitted electronically to the Member's pharmacy.
17) **"Formulary"** means the listing of drugs, pharmaceutical products, and devices that are covered by the applicable Plan that is developed and revised by Capital Rx which may be pursuant to direction of the applicable Plan.
18) **"Generic Drug Product"** means a drug that is either a Multi-Source Generic or a Single-Source Generic.

19) **"Home Infusion"** (HI) Pharmacy is a Pharmacy-based, decentralized patient care organization with expertise in USP 797-compliant sterile drug compounding that provides care to patients with acute or chronic conditions generally pertaining to parenteral administration of drugs, biologics and nutritional formulae administered through catheters and/or needles in home and alternate sites. Extensive professional pharmacy services, care coordination, infusion nursing services, supplies and equipment are provided to optimize efficacy and compliance. For purposes of Medicare, PBM shall designate the pharmacies with a NCPDP primary provider Type Code "06" Home Infusion Therapy Provider as a Home Infusion pharmacy.
20) **"Indian Health Services, Tribal or Urban Indian Health, or I/T/U"** is a retail pharmacy operated by the Indian Health Service, an Indian tribe or tribal organization or an urban Indian organization as defined in Section 4 of the Indian Health Care Improvement Act, 25 U.S.C. 1603. These pharmacies are identified by a National Council for Prescription Drug Program's (NCPDP) dispenser type code of 8.
21) **"Ingredient Cost" means the component of Pharmacy Reimbursement Rate related to the Prescription Drug ingredient.**
22) **"Long Term Care (LTC) Pharmacy"** is a pharmacy that dispenses medicinal preparations delivered to patients residing within an intermediate or skilled nursing facility, including intermediate care facilities for mentally retarded, hospice, assisted living facilities, group homes, and other forms of congregate living arrangements. For purposes of Medicare, "LTC Pharmacy" shall have the same meaning as the term "long term care network pharmacy" under 42 CFR § 423.100, as amended from time to time and Claims submitted with a patient residence code of 3 or 9 shall be deemed LTC Claims.
23) **"Mail Order Pharmacy"** is a pharmacy where pharmacists compound or dispense prescriptions or other medications in accordance with federal and state law, using common carriers to deliver the medications to patient or their caregivers. Mail order pharmacies counsel patients and caregivers (sometimes independent of the dispensing process) through telephone or email contact and provide other professional services associated with pharmaceutical care appropriate to the setting. Mail order pharmacies are licensed as a Mail Order Pharmacy in the state where they are located and may also be licensed or registered as nonresident pharmacies in other states. Pharmacies that mail, send via courier or common carrier, or otherwise ship Prescription Drugs 51% of the time shall be considered a Mail Order Pharmacy and shall be required to maintain an applicable Mail Order Agreement with Capital Rx.
24) **"Member"** means an individual who is enrolled with a Plan Sponsor that is entitled to receive Covered Prescription Services.
25) **"Multi-Source Brand"** means those Prescription Drug(s) identified as "O" by Medi-Span's Multi-Source Code indicator.
26) **"Multi-Source Generic"** means those Prescription Drug(s) identified as "Y" by Medi-Span's Multi-Source Code indicator.
27) **"NADAC"** means the National Average Drug Acquisition Cost list published by the Centers for Medicare and Medicaid Services (CMS).
28) **"NCPDP"** means the National Council of Prescription Drug Programs.
29) **"Network"** means Capital Rx's pharmacy participation network(s) designed to offer access to Covered Prescription Services to Members under Plans.
30) **"NPPES"** means National Plan and Provider Enrollment System.
31) **"OTC Drug"** means a Drug with a Medi-Span Rx-OTC Indicator Code of "O" or "P."
32) **"Pharmacy Reimbursement Rates"** means the agreed upon Ingredient Cost and Dispensing Fee rates, Incentive Fees or other rates that make up total reimbursement that Capital Rx has agreed to pay Pharmacy for the provision of, and payment for Covered Prescription Services.
33) **"Pharmacy Services Administration Organization (PSAO)"** means an administrator that contracts on behalf of a collective group of independent pharmacies. Independent pharmacies affiliated with a contracted PSAO provides services to Capital Rx through that delegated relationship.

34) **"Plan"** means the benefit to Members which may include, but is not limited to any Medicaid, Medicare Part D Plan, or other prescription drug plan, discount card programs and workers compensation programs that are operated, offered or provided by Capital Rx or Plan Sponsors that entitle Members to receive reimbursement for, or payment of Covered Prescription Services.
35) **"Plan Sponsor"** means, including, but not limited to, an employer, health insurer, managed care organization, union health and welfare trust, government agency or third party or pharmacy benefit administrator that operates, offers or provides the Plan(s) through PBM.
36) **"POS System"** means the online or real time (point-of-sale) telecommunication system used to communicate information including, but not limited to, Covered Prescription Services.
37) **"Prescription Drug"** means a pharmaceutical or pharmaceutical compound that under applicable law requires a prescription.
38) **"Provider Manual"** means but is not limited to the guidelines, policies and procedures regarding standards of practice, Plan specifications and additional terms and conditions to the Agreement to which Pharmacy is required to adhere. The Provider Manual is incorporated by reference into the Agreement.
39) **"Retail Pharmacy"** is a pharmacy where pharmacists store, prepare, and dispense medicinal preparations and/or prescriptions for a local patient population in accordance with federal and state law; counsel patients and caregivers (sometimes independent of the dispensing process); administer vaccinations; and provide other professional services associated with pharmaceutical care such as health screenings, consultative services with other health care providers, collaborative practice, disease state management, and education classes. A retail pharmacy does not self-identify with NCPDP as a Mail Order Pharmacy (dispenser type code of "5") or Specialty Pharmacy (dispenser type code of "15"). A retail pharmacy does not advertise itself as a Mail Order Pharmacy. The retail pharmacy represents that its primary method of dispensing or distributing Prescription Drugs, divides, or non-prescription drugs is not by mail or another common carrier.
40) **"Rural Retail Pharmacy"** is a pharmacy that is located more than fifteen (15) miles from another pharmacy's location, per the address on the NCPDP DataQ, irrespective of city, county, and state lines.
41) **"Single-Source Brand"** means those Prescription Drug(s) identified as "M" or "N" by Medi-Span's Multi-Source Code and additionally as "B" or "T" by Medi-Span's Name Type Code.
42) **"Single-Source Generic"** mean those Prescription Drug(s) identified as "M" or "N" by Medi-Span's Multi-Source Code and additionally as "G" by Medi-Span's Name Type Code.
43) **"Specialty Drugs"** means Prescription Drugs that are typically used to treat chronic or complex conditions, and typically have one or more of several key characteristics, including frequent dosing adjustments and intensive clinical monitoring to decrease the potential for drug toxicity and increase the probability for beneficial treatment outcomes; intensive patient training and compliance assistance to facilitate therapeutic goals; limited or exclusive product availability and distribution (if a drug is only available through limited specialty pharmacy distribution it is always considered a Specialty Drug); specialized product handling and/or administration requirements; or costs $600 or more on a monthly basis. Specialty Drugs may be administered by any route of administration. Specialty Drugs include biosimilars. Specialty Drugs shall be deemed those drugs on the PBM's Specialty Drug List, and any added to the Specialty Drug List after the Effective Date.
44) **"Specialty Pharmacy"** is a pharmacy that (1) is licensed under Law, (2) dispenses Specialty Drugs to Members through the U.S. mail or a commercial carrier service, (3) dispenses generally low volume and high cost medicinal preparations to patients who are undergoing intensive therapies for illnesses that are generally chronic and complex; often these therapies require specialized delivery and administration and (4) has entered into an agreement with, or is an Affiliate of, Capital Rx in order to provide Covered Pharmaceuticals to Members. For purposes of this Agreement, a Retail Pharmacy is not a Specialty Pharmacy.
45) **"Usual and Customary" or "U&C"** means the lowest price Pharmacy would charge to a particular customer if such customer were paying cash for the identical Covered Prescription Services on the date dispensed. This includes any applicable discounts, including, but not limited to, advertised or

sales prices, price matching, coupons, senior discounts, frequent shopper discounts, pharmacy provider's savings or discount programs with or without an enrollment fee, any program that offers medication at no cost (e.g. a U&C of $0.00 should be submitted) and other special discounts offered to attract customers. The PHARMACY is required to report an accurate U&C and must not underreport or conceal U&C for prescription services.

46) **"Vaccine"** means a Claim for a Covered Pharmaceutical that is a substance used to stimulate the production of antibodies and provide immunity against one or several diseases.
47) **"340B Drug Pricing Program"** means the program established under Section 340B of the Public Health Service Act that allows for drugs to be acquired at a reduced amount.
48) **"340B Covered Entity"** means the healthcare organization that is entitled to access the 340B Drug Pricing Program for itself or for pharmacies with which it may contract.
49) **"340B Pharmacy"** means a pharmacy that is entitled to access the 340B Drug Pricing Program through a contract with a 340B Covered Entity.

II. Provider Relations

1) Joining the Capital Rx Pharmacy Networks

In order to join the Capital Rx pharmacy network(s), please submit a request to the Capital Rx Provider Relations team at Provider.Relations@cap-rx.com.

Contracted pharmacies will be notified of changes to fee schedules and or contracting provisions either through updates to the provider manual or electronic communication, unless an alternative method is agreed upon.

2) PSAO Requirements

a) PSAO Requirements

Each PSAO attests that it has all necessary authority to enter into an agreement with Capital Rx on behalf of its participating pharmacies. Such participating pharmacies are therefore required to comply with any applicable terms or obligations in the agreement signed on their behalf by the PSAO. Each PSAO is required to routinely update the information regarding their participating pharmacy locations in the NCPDP database so as to ensure all pharmacies affiliated with the PSAO are credentialed and contracted as well as to ensure that the NCPDP database has complete and accurate information. PSAO understands that Capital Rx relies on the information in the NCPDP database and as such attests the information in the NCPDP database is accurate. In order to properly remove a pharmacy from affiliation with the PSAO, such pharmacy affiliation must be removed from the NCPDP database at the individual pharmacy level. PSAO is also responsible for ensuring the integrity of any data and reconciling such information with NCPDP as required. Upon reasonable request, PSAO and/or its participating pharmacies as applicable is/are required to respond to Capital Rx promptly upon receipt of a request for documentation necessary to support claims processing or credentialing initiatives. PSAOs are further required to share all relevant information upon request from Capital Rx.

Capital Rx and/or Plan Sponsors may immediately limit or exclude any pharmacy location affiliated with PSAO from participating in applicable network(s) under the terms and conditions of the Agreement. In addition, pharmacy locations affiliated with PSAO may be excluded from participating in applicable network(s) for reasons including: (i) the pharmacy location is a Mail Order Pharmacy or provides Covered Prescription Services in violation of the Agreement; (ii) the pharmacy location is independently contracted directly with Capital Rx; (iii) the pharmacy location

has been identified as a 340B pharmacy and contracted independently Capital Rx as such; (iv) pharmacy location does not maintain a valid DEA License or had its DEA license revoked; (v) a pharmacy network is geographic-specific; (vi) the pharmacy location requires a Medicaid ID number for participation. In the event any pharmacy location is excluded for any of the aforementioned reasons, such pharmacy may contact Capital Rx directly for a contract per the contact information listed herein.

3) Credentialing

a) General Credentialing

Capital Rx has a credentialing program to ensure that the pharmacies that provide services to its Plans and Members are valid and properly licensed. Pharmacy is required to comply with Capital Rx's credentialing program requirements of which include:

- **i)** Providing copies of all relevant licenses such as state pharmacy and DEA licenses and/or permits upon joining the Capital Rx Networks and thereafter providing updates to those licenses and/or permits as needed promptly (at least within 3 business days of any change to such licenses and/or permits);
- **ii)** Provide a copy of the applicable certificate of insurance;
- **iii)** Provide not less than ten (10) days prior written notice of any cancellation, termination, or material change to such insurance policy(ies);Providing copies of relevant documentation or other information requested of it in a timely manner (typically within forty-eight (48) hours of request);
- **iv)** Maintaining updated and accurate information in the NCPDP database;
- **v)** Maintaining updated and accurate information in the NPPES database;
- **vi)** Meeting all applicable standards of operation as required by law and/or regulations;
- **vii)** Maintaining all applicable licenses and/or permits in good standing with federal, state and/or local agencies or authorities;
- **viii)** Providing Capital Rx with prompt written notification (at least within seven (7) days) of the occurrence of any of the below:
  - **(1)** A license or permit of Pharmacy or any of its locations is likely to be suspended or revoked;
  - **(2)** Pharmacy or any of its locations is likely to be disciplined or receives notice or any situation, claim or proceeding that could lead to potential disciplinary action;
  - **(3)** Pharmacy, any of its locations or personnel is the subject of any disciplinary action including but not limited to disciplinary actions by any state or federal board of pharmacy, OIG, GSA or other law enforcement or regulatory body;
  - **(4)** Pharmacy or any of its locations receive a subpoena for records that are applicable to the services Pharmacy and its locations provide to Capital Rx;
  - **(5)** Pharmacy's records, systems or property are seized by law enforcement; or
  - **(6)** Pharmacy or any of its locations or personnel are the subject of any investigation.

****Note that Capital Rx may require enhanced credentialing based on Pharmacy's provider type, the services Pharmacy offers, pursuant to Client direction or legal requirements in which case Capital Rx will notify Pharmacy of such additional requirements it needs to complete.

Capital Rx may deny, terminate, suspend or revoke Pharmacy or any of its locations from any or all Networks as a result of Pharmacy's failure to comply with Capital Rx's credentialing program. In addition, if Capital Rx reasonably believes that Pharmacy or any of its locations or personnel has (i) engaged in any activity that poses a risk to the health, welfare or safety of a Member or the general public, (ii) engaged in behavior that suggests licenses and requirements for such licenses have not been properly maintained, or (iii) engaged in behavior that may reflect negatively on Pharmacy, its locations or personnel and their

ability to provide services in accordance with the Agreement, Capital Rx shall have the right to immediately limit or suspend Pharmacy or any of its locations from any or all Networks.

Note that Capital Rx may require mail order/delivery pharmacies, specialty pharmacies, compounding pharmacies and home infusion pharmacies to complete additional credentialing which will be communicated to such pharmacies as applicable. These additional requirements may include accreditation with Verified Internet Pharmacy Practice Sites (VIPPS) (vipps.nadp.net) and/or URAC (urac.org). Additionally, Capital Rx reserves the right to require enhanced or additional credentialing for state, federal or other health plans.

Pharmacies are required to re-credential with Capital Rx every three (3) years or such lesser period time as determined by applicable by state or federal regulations.

b) Cultural Competency Training and Abuse, Neglect and Exploitation Training. Pharmacies are required to be aware of the cultural differences of our Members to promote the provision of services in a manner that addresses the diversity of the Member population and free of bias including, but not limited to, those with limited English proficiency, diverse cultural/ethnic backgrounds and mental and physical disabilities. Such training must be provided to staff at all applicable levels.

Pharmacies are also required to promote an environment free from discrimination based on gender, sexual orientation and/or gender identity. Pharmacies should be aware of any issues related to abuse, neglect, national origin and/or exploitation, and report any concerns to the appropriate state agency when warranted.

c) PSAO Credentialing

If Pharmacy is a PSAO, Pharmacy attests/certifies that it has and maintains credentialing and compliance monitoring programs for itself and each of its affiliated pharmacies and that it and all pharmacies affiliated with it meet and will continue to comply with Capital Rx's credentialing program and compliance initiatives including ensuring that (i) all affiliated pharmacies update and maintain accurate pharmacy information in the NCPDP database, (ii) PSAO reviews and primary source verifies the DEA licenses and Pharmacy licenses, and verifies insurance coverage, exclusion and debarment information of its affiliated pharmacies as well as any disciplinary action imposed upon any of its affiliated pharmacies on a monthly basis and provide any relevant information to Capital Rx, (iii) any affiliated pharmacy, pharmacist, subcontractor or other personnel (including temporary personnel) that provides services to Members in the Capital Rx Networks have not been nor will be debarred, excluded or otherwise ineligible to participate in any federal, state or local government funded health care programs or convicted of a felony. If PSAO becomes aware that any affiliated pharmacy, pharmacist, subcontractor or other personnel (including temporary personnel) that provides services to Members in the Capital Rx Networks have been or are likely to be debarred, excluded or otherwise ineligible to participate in any federal, state or local government funded health care programs or convicted of a felony, PSAO shall immediately notify Capital Rx in writing and prevent such personnel or pharmacy location from providing services to Members. In such event, Capital Rx shall have the right to immediately terminate the applicable pharmacy location from the Capital Rx Networks whether or not the location itself or its personnel were or are the subject of the debarment, exclusion ineligibility or felony conviction. If PSAO itself is debarred, excluded or otherwise ineligible to participate in government funded programs or it has not complied with the actions required of it herein, Capital Rx shall have the right to take remedial actions it reasonably deems appropriate or immediately terminate the Agreement upon written notice to PSAO.

Capital Rx and/or its Clients shall have the right to monitor Pharmacy's credentialing program and may request access to Pharmacy's records to do so upon reasonable advance notice unless fraud is suspected. Pharmacy shall do its best to comply with such requests and promptly provide the information requested of it. In addition, Capital Rx and/or its Clients may verify the licenses or permits, insurance, exclusion/debarment status, or disciplinary actions of Pharmacy and/or its affiliated pharmacies and/or any applicable personnel which may include onsite visits to Pharmacy location(s).

In addition to the other requirements outlined herein, PSAO affiliated pharmacies are required to meet the following requirements:

i) Have and maintain proper licensing in the applicable state of residence;
ii) Have and maintain a DEA license;
iii) Have and maintain liability insurance at the minimum amounts below;
    - $1,000,000 per occurrence
    - $3,000,000 aggregate
iv) Not listed on any exclusion lists or databases including the lists found through the Office of Inspector General's (OIG), U.S. Department of Health and Human Services (HHS) List of Excluded Individuals/Entities (LEIE), General Serves Administration (GSA) System for Award Management (SAM) Excluded Parties Listing System (EPLS); this requirement applies to both the pharmacy owner and the pharmacy itself;
v) Not sanctioned or limited in any way that would prohibit the pharmacy location from fulfilling its obligations hereunder;
vi) Meets the obligations outlined in the Agreement for participation;
vii) Abides by the pharmacist-in-charge (PIC) and personnel requirements below:
    - PIC has and maintains all appropriate licenses
    - PIC and any pharmacist of other personnel are not listed on any exclusion lists or databases including the lists found through the OIG, HHS LEIE, GSA SAM EPLS
    - PIC has and maintains the minimum insurance levels required by the applicable state
    - PIC has not been restricted, sanctioned or otherwise limited within the most recent three-year period

Failure by PSAO or any of its affiliated pharmacies to comply with Capital Rx's credentialing program may result in termination or suspension of Pharmacy and/or any of its affiliated pharmacies from any or all Networks.

Pharmacy understands Capital Rx relies on the information about it's network pharmacy providers, as well at each Pharmacy location provided by NCDPD and directly to Capital Rx, therefore, network pharmacy provider:

- Agrees to update in a timely manner all information in NCPDP database whenever necessary as to ensure the information in the database is accurate as Capital Rx updates pharmacy provider profiles and may be displayed to members via on-line or paper directories.
- Information includes, but not limited to, changes in name, address, telephone number, email address, services, NPI, NCPDP, licensure information (e.g. State license, DEA registration), tax identification ID changes, Medicaid ID, provider affiliation, ownership information, provider dispensing type, certificate of insurance, cultural competency training indicator, FWA training indicator.

Pharmacies are also encouraged to update their information, including all taxonomy codes, on the National Plan and Provider Enrollment System (NPPES) as the following location: https://nppes.cms.hhs.gov. The information on MPPES including your pharmacy taxonomy information, may be used for network and contract validation by Capital Rx, Clients, and CMS.

4) Addition to Network

Pharmacies will not be added to Capital Rx's network until they have been properly credentialed. If Capital Rx receives notification from a PSAO/TPA of a new service relationship starting after the first of the month, the effective or start date will be the first of the following month. This includes updates to the service relationship ID in NCPDP.

5) Pharmacy Compliance

Capital Rx appreciates your participation in its Networks and in the role you play in providing services to our Members. In order to ensure that the pharmacy services you provide are compliant, please make sure to abide by the terms of this Provider Manual and any changes made to it all of which are effective upon publication of such changes unless noted otherwise. In addition, Capital Rx requires its Pharmacy partners and their applicable personnel to be, and remain in, compliance with all applicable law and regulations including those outlined herein. From time to time Capital Rx may send a notice or communication to applicable pharmacies to address certain legal or regulatory issues or guidance or to address potential fraud, waste, abuse trends discovered through routine audit processes or otherwise made known to Capital Rx.

Please note that Pharmacy's participation in one (1) or more of Capital Rx's Networks shall not guarantee participation in any or all Networks. Capital Rx reserves the right to limit Pharmacy or any of Pharmacy's locations in any network in its sole discretion or pursuant to Client direction.

Capital Rx is reliant upon Pharmacy's participation in its networks and accordingly Pharmacy will not be allowed to opt out of any network without PBM's written consent (which will not be unreasonably withheld), unless applicable law requires Pharmacy to have the ability to opt out of individual networks.

Note that mail and specialty pharmacy partners may be subject to certain performance requirements as outlined in the applicable agreements. In the event an applicable pharmacy does not meet its performance requirements for the given time period, such pharmacy may be subject to certain corrective measures including remediation or corrective action plans to address such failings.

Please note that nothing in this Manual or your Agreement is intended to restrict conversations between pharmacy personnel and Members related to any differential between the Member's cost under their plan or if no insurance coverage is used, more affordable alternative options, or any other subject matter allowed by applicable law.

a) Prohibited Activities

In addition to any other prohibited activity listed in this Provider Manual or the Agreement, Pharmacy is prohibited from engaging in the following activities:

- Disclosing any confidential information to a Client or potential Client;
- Disparaging or disrupting the relationship between Capital Rx and any of its Clients or potential clients; or

- Soliciting a Member or Client to terminate its relationship with Capital Rx

In the event Pharmacy engages in any prohibited activity, Capital Rx shall have the right to take remedial actions including immediate termination of Pharmacy from any or all Network(s).

b) Drug Purchases and Transfers

Pharmacy is required to purchase covered drug products for any Claims submitted to Capital Rx from a NABP-VAWD (Verified–Accredited Wholesaler Distributors) licensed wholesaler as regulated by state and federal entities. This requirement includes the purchase of non-legend items (e.g. OTC, supplies). Pharmacy must be able to document the source is authorized to include federal/state licensure, oversight by regulatory agencies to include the Food and Drug Administration (FDA), DEA and ability to obtain pedigree information for drug products. Pharmacy is prohibited from entering into a captive pharmacy arrangement, whereby Pharmacy agrees to market and dispense drug products specifically for a manufacturer without disclosure to and written approval from Capital Rx. In addition, any inter-pharmacy transfers must be accurately and completely documented in a manner consistent with federal and/or state laws and industry standards.

A Pharmacy may transfer inventory to alleviate a temporary shortage or for the sale, transfer, merger or consolidation of all or part of the business of a pharmacy from or with another pharmacy, whether accomplished as a purchase and sale of stock or business assets. On the day the drug products or medical supplies are transferred, a complete inventory must be taken which documents the drug name, dosage form, strength, NDC, lot number, quantity and date transferred. Additionally, documents must indicate the supplier or manufacturer's name, address and registration number. All records involved in the transfer must be maintained and accessible for six (6) years.

In order to ensure Pharmacy is complying with these requirements, Capital Rx may request to review Pharmacy's relevant documentation and Pharmacy must promptly comply with any such requests.

c) Records

Pharmacy is required to keep and maintain in accordance with industry standards and practices, applicable law, boards of pharmacy requirements, Plan Sponsor and industry standards, and the Agreement and this Provider Manual accurate and complete records and accounts of all transactions including without limitation: patient records and information, data, prescription files, financial records, databases, daily Prescription logs, patient profiles, prescription hardcopies, prescriber information, signature/delivery logs, refill information, wholesaler/manufacturer/distributor/all other purchase invoices from a NABP accredited source, business records such as Fraud, Waste and Abuse training logs, LEIE/EPLS verifications, and other related and applicable files, and other related documents related to the provision of Covered Prescription Services. PHARMACY shall maintain all such Records for at least ten (10) ten years from the date the Covered Prescription Service is dispensed or longer if required by law.

Prescription Records shall include relevant information including the following:

i) Full name, address and date of birth of the applicable Member for whom the prescription was written;
ii) Full name, address, telephone number and any other required identifier for the prescriber;
iii) Name, strength, dosage form and quantity of the prescribed medication;
iv) Dosing directions (if a prescription contains ambiguous directions, Pharmacy personnel must clarify the directions and note the conversation to clarify);

v) Substitution instructions where applicable, or substitution requested by Member clearly noted;
vi) Refill instructions if applicable;
vii) Miscellaneous or other informational notes and all other data elements (e.g. Product Selection Code instructions) as required by applicable laws or regulations; and
viii) Complete documentation of items, quantities to be dispensed and directions for use for diabetic supplies and insulin.
Pharmacy is required to update, including any assignment of a new prescription number, prescription records annually or at such other frequency as required by applicable law. In addition, Pharmacy is encouraged to note as much information as possible on the prescription including detailing anything abnormal that occurred in dispensing so as to help provide answers to Auditors' questions or resolve discrepancies.
For prescriptions that have dosage or quantity changes, written documentation on the prescription, time-stamped electronic notations or a new hard copy prescription is required. For prescriptions on which the prescriber has written "as directed", information outlining at a minimum the maximum dose of medication taken per day or the exact instructions must be documented on the hard copy or noted electronically and viewable when requested. Note that only prescriber-generated prescriptions may be accepted by Capital Rx or the Auditors as post audit documentation for "as directed" prescriptions. If less medication is dispensed than what was ordered in the prescription, Pharmacy must document the reason for such decrease and, if more medication was dispensed than the total amount authorized by the prescription, the prescriber must authorize such increase.
ix) Any clarifications of missing or ambiguous information should be documented on the prescription or an electronically time-stamped note within the pharmacy system. This note shall include the prescriber or nurse authorizing the change, date of clarification and the initials or name of pharmacy representative making the notation.
x) Electronic prescription records should be readily retrievable and include the front and back (if applicable) images of the prescription. The hard copy shall be retained and retrieved if needed for audit.

d) Signature Log

Pharmacy is required to maintain a signature log that contains all of the customary information necessary for Capital Rx to confirm proper receipt of the Covered Prescription Services including but not limited to the prescription number for the underlying Covered Prescription Service, the date on which the Claim was approved, the date on which the prescription was dispensed, the product dispensed, Co-payment amounts, an authorization for release of information to Capital Rx and Plan Sponsor in order to process the Claim and the signature of the Member or authorized agent (where permitted by law) confirming receipt of the prescription. Pharmacy shall maintain the signature log for a period of not less than ten (10) years or such longer period of time as mandated by applicable law. If Pharmacy chooses to use an alternative method for documentation of receipt of Covered Prescription Services, Pharmacy shall provide sufficient information to Capital Rx whereby Capital Rx will determine in its sole discretion whether such alternative method is acceptable. Any such approval shall be obtained from Capital Rx in writing.

If a prescription is delivered to a home or business address, Pharmacy is required to obtain the signature of the Member or the Member's designee at the time of delivery. If the Member is sent a monthly billing statement, Pharmacy may insert a form listing the dates of fill and prescription numbers. The applicable Member or Member's authorized representative should be instructed to sign and return the form with payment. If Pharmacy is using mail services, Pharmacy is required to include information to document tracking of shipment, confirmation of delivery, or other proof of delivery.

All signature logs must be maintained in order by date as appropriate and readily accessible. An original or digital image of a signature log will suffice as evidence of receipt of goods.

e) Pharmacist Counseling

Pharmacy shall ensure that the Pharmacist are complying with any and all State and Federal laws or regulations on patient medication counseling including but not limited to the use of, side effects, disposal of expired, damaged, and unstable medications.

f) Pharmacy Storage and Mailing Conditions

Pharmacy shall take appropriate measures to ensure compliance with the guideline set forth by the USDA regarding medication's therapeutic integrity. Mail Order and Specialty Network Pharmacies shall also take appropriate measures and ensure that all temperature-sensitive Covered Prescription Services are dispensed directly to the Member or delivered under appropriate conditions to ensure stability and quality standards by overnight delivery to all locations within the United States.

g) Controlled Substances

Pharmacy shall be properly licensed prior to dispensing any controlled substances and follow any and all State and or Federal laws or regulations when dispensing controlled substances. Controlled substances that are shipped must also be done so in a secure manner to ensure proper delivery following any and all State and or Federal regulations.

h) Disaster Recovery Plan

Pharmacy shall have a disaster recovery plan consistent with the highest industry standards that enables Pharmacy to perform its duties, obligations, and services hereunder within forty-eight (48) hours of a disaster. In the event that it becomes impracticable, for reasons of a force majeure or otherwise, for Pharmacy to dispense Covered Prescription Services to Eligible Members as required hereunder, Pharmacy shall notify Capital Rx and use best efforts to have Covered Prescription Services dispensed from an alternate/backup pharmacy as detailed in Pharmacy's disaster recovery plan, subject to applicable laws and Plan requirements. Pharmacy shall furnish Capital Rx with a copy of its disaster recovery plan upon request and whenever changes are made to such disaster recovery plan.

i) Disposal of Hazardous waste/substances

Pharmacy shall dispose of hazardous waste/substances according to any and all State and Federal laws and regulations to prevent diversion and other abuses.

j) Pharmacy Physical Location

Pharmacy shall maintain a full array of different therapy classes of medications at all times for the applicable dispensing to members. Pharmacies must have the appropriate staff present when filling and dispensing any and all medications. Pharmacy shall maintain core hours of operations no less than 5 days a week. Notwithstanding the foregoing pharmacy shall comply with any and all State and or Federal laws or regulations regarding their physical pharmacy location

k) Off-Label Medication Usage

i) Usage of medications for a non-FDA approved medication must be done so under the supervision of a licensed pharmacist, consistent with plan benefit design, applicable drug formulary, while in accordance with professional standards prevailing at the time services are rendered.
ii) Pharmacy partners must determine that claims are submitted for a valid use of the medication. In the event prescription orders are inconsistent with manufacturer prescribing information, pharmacy must provide documentation to support the appropriate dispensing of medications based on standard industry practice as part of an audit.
iii) The supporting scientific evidence must show:
    (1) Consistent and adequate number of well-designed studies with sufficient patients in relation to the incidence of the disease being treated.
    (2) Publication in major peer-reviewed journals based on manuscripts that have been critically reviewed by unbiased independent experts for scientific accuracy, validity and reliability.
    (3) Studies should include consistent results for specific diseases and treatments.
    (4) Must demonstrate that the drug is as effective or more effective than FDA-approved alternatives.
    (5) The patient has an FDA labeled indication, or an indication supported in AHFS, DrugDex with 1 or 2a level of evidence, or NCCN with 1 or 2a level of evidence for the requested agent
iv) The following materials do not meet the expectations of standard industry practice:
    (1) Clinical studies administered that do not present direct correlation to intended use, strength, dosage form or route of administration.
    (2) Manufacturer-sponsored studies for non-FDA approved uses.
    (3) Patient case reports.
v) When use is consistent with high-quality, evidence-backed literature, requests may be granted if alternative preferred treatment options have been adequately trialed or are not appropriate.

6) Applicable law and Regulations

Below are applicable law and regulations to which Pharmacy is required to adhere. Please note that this list is not all inclusive and Pharmacy is responsible for reviewing applicable state and federal law and regulations and making sure it, its pharmacists, and other personnel are in compliance with any such applicable laws or regulations.

a) Fraud, Waste and Abuse (FWA):

i) **Fraud**: Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program; or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 United States Code §1347).
ii) **Waste**: Overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.
iii) **Abuse**: Actions including those that may, directly or indirectly, result in unnecessary costs to the Medicare and Medicaid Programs, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the

distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.

b) Federal and State Anti- Kickback Statutes

i) Examples of FWA (intended for educational purposes only and not intended to be an all-inclusive list):

(1) Examples of FWA by prescribers:

(a) Illegal remuneration schemes in which a prescriber or Member is offered, paid, solicited or receives remuneration that is illegal to induce or reward them for inappropriate behavior;

(b) Script mills in which a prescriber writes prescriptions that are not necessary including for people that are not the prescriber's patients;

(c) Illegal usage of free samples in which samples are provided knowing that the prescriber will bill payers for the free samples.

(2) Examples by Members:

(a) Member seeks, obtains and uses a Drug that poses more of a risk than a benefit to the Member;

(b) Member alters the information on a valid prescription or writes an illegal prescription;

(c) Member obtains a Drug but gives or sells that Drug to someone else.

c) In addition to the examples outlined above, below are some common examples of fraud, waste and abuse. The examples outlined herein are just for educational purposes and are not meant to list every example of fraud, waste or abuse. If Pharmacy engages in any of the activities outlined in these examples or in other fraud, waste or abuse activities, Pharmacy may be subject to remedial measures including audit, sanctions, suspension or termination from the Capital Rx Networks.

(1) Billing for a Brand Drug Product and dispensing a Generic Drug Product;

(2) Billing for a NDC other than what was dispensed;

(3) Overbilling of quantity prescribed;

(4) Billing multiple payers for the same Prescription;

(5) Inappropriate billing of compounded drugs;

(6) Submitting a dummy DEA/NPI or Invalid DEA/NPI number to obtain a paid response;

(7) Billing for a Brand Drug Product with Dispense as Written per the Prescriber (DAW 1) when a prescriber has not specified "Do Not Substitute" on the prescription or other inappropriate use of DAW codes;

(8) Billing for larger pack sizes of drug products supplied in unbreakable packages when one smaller pack size will meet the directions of the prescriber and remain within the benefit plan's maximum days' supply;

(9) Billing for more fills or refills than were authorized;

(10) Splitting prescriptions into multiple Claims to obtain multiple dispensing fees or undermine a prior authorization or quantity limits, etc.;

(11) Diluting the drug product provided to a Member;

(12) Acquiring prescription drugs on the black market and/or through black market sales;

(13) Colluding with a prescriber, wholesaler or others and kickback schemes

(14) Selling the same drug product twice (i.e. recycling pills);

(15) LTC Pharmacy billing for unused Covered Prescription Services and not applying credit to the applicable Member;

(16) Inappropriate, inaccurate or incomplete record-keeping practices related to billed prescriptions;

(17) Prospective billing;

(18) Phantom Claim billing (Claims for Covered Prescription Services not provided);

(19) Dispensing expired or adulterated prescription drug products;

(20) Forging or altering prescriptions;
(21) Refilling prescriptions erroneously;
(22) True out of pocket cost manipulation;
(23) Billing for prescriptions which are invalid due to invalid/illegal prescriber, forgery, or false or fictitious documents; and
(24) Billing for more medication or drug product than dispensed (i.e. pill shorting).

d) Capital Rx requires Pharmacy to report any actual, suspected or potential acts of fraud, waste or abuse to it as soon as possible. Capital Rx has a strict non-retaliation policy that protects anyone that reports fraud, waste or abuse to it in good faith.

In the event a potential fraud, waste or abuse or other compliance issue has been reported to Pharmacy, Pharmacy should begin an investigation as soon as possible (but not more than two (2) weeks) from the date the issue was reported or identified. If, after the investigation concluded, Pharmacy reasonably believes misconduct has occurred or potentially has occurred, Pharmacy shall notify Capital Rx immediately. Pharmacy shall not be retaliated against (as stated above) for such good faith report(s).

If Pharmacy provides services to a Medicare Part D or Medicaid Plan's Members, Pharmacy is responsible for (i) having and maintaining a program to prevent and control fraud, waste and abuse, (ii) facilitating compliance in its delivery of services through the Medicare Part D or Medicaid benefits (iii) ensuring that the fraud, waste and abuse certification program via NCPDP and its accompanying attestation are completed for Pharmacy and any affiliated pharmacies.

In the event Pharmacy, a pharmacist, or other personnel suspects a Member or Managed Care Organization is engaging in fraud or abuse, such Pharmacy, pharmacist or personnel must report this to the applicable federal or state agency and to Capital Rx.

In the event Pharmacy or a pharmacist, or other personnel suspects pharmacy location, pharmacist, or personnel is engaging in fraud, abuse or inappropriate billing practices, such Pharmacy, pharmacist or personnel must report this to the appropriate authority and to Capital Rx.

In addition to the reporting requirements listed herein, Pharmacy is required to cooperate and assist any federal or state agency tasked with identifying, investigating, sanctioning or prosecuting suspected fraud, waste or abuse. Pharmacy must provide original and/or copies of any and all information (including records) as requested by any such federal or state agency or investigating agency (free of charge) and shall allow such investigating entities access to its premises.

7) Fraud, Waste and Abuse Attestation and Training

Pharmacy is required to have and maintain a program to monitor and train its applicable personnel on compliance matters and fraud, waste and abuse. Such personnel must be trained upon hire and at least annually thereafter. Pharmacy is required to attest each year by December 31st that such training has occurred and that it is in compliance with all applicable law and regulations and other mandatory requirements related to guidance from government entities such as the Center for Medicare and Medicaid Services (CMS).

In addition, CMS has provided guidance within the Federal Register at 42 CFR Parts 422 and 423 and other agency guidance requiring Medicare Part D Plan Sponsors or their delegates, first tier, downstream or related entities to demonstrate compliance with the following if Pharmacy is in a Capital Rx Medicare Part D Network:

Pharmacy hereby verifies and certifies it has completed satisfactory annual Fraud, Waste and Abuse and general compliance training programs provided by CMS

In the event Pharmacy is a Pharmacy Services Administrative Organization (PSAO), Pharmacy shall comply with the attestation requirements herein by providing a single attestation on behalf of its entire membership of pharmacies.

8) Pharmacy and Pharmacy Personnel Exclusion

Pharmacy is required to ensure that none of its pharmacy locations, applicable pharmacists or other personnel, subcontracted delegates and/or other contractors are excluded from participation in federal or state health care programs such as Medicare Part D or Medicaid by reviewing exclusion lists maintained by the Office of Inspector General (OIG) U.S. Department of Health and Human Services (HHS), U.S. General Services Administration (GSA) System for Award Management (SAM), and any applicable state or Medicaid exclusion list. Pharmacy must review these lists upon hire of any applicable pharmacist, other personnel, subcontracted delegate and/or other contractor and monthly thereafter and as required by applicable law. Pharmacy attests that it performs these exclusion reviews upon hire and monthly thereafter and that no applicable pharmacist, other personnel, subcontracted delegate and/or other contractor is excluded.

9) Quality Related Issues and Requirements and Member Complaints

a) If Capital Rx identifies a quality related or service issue as a result of a member complaint, prescriber response, audit, call center discussion or through another avenue, and Capital Rx confirms that the issue occurred with the Pharmacy, Pharmacy will review the information with the Member, document such issue according to its own policies and procedures and report the issue to the appropriate government or regulatory authority as necessary (such as the Institute of Safe Medical Practices). If the issue was related to a paid Claim, Capital Rx reserves the right to reverse the Claim or recoup payment for the Claim.

b) Capital Rx wants to ensure that Members and/or prescribers have a mechanism to appeal denials and a Member (or their representative) or prescriber that wants to appeal a denial should follow the appeal information outlined in the appeal letter. In addition, if a Member submits a grievance or complaint to Capital Rx, a Plan or Pharmacy, Pharmacy shall fully cooperate with Capital Rx and/or the Plan in investigating and resolving the complaint or grievance in a timely manner. Such cooperation may include allowing Capital Rx or a Plan to visit the applicable Pharmacy location and submitting evidence of corrective actions and/or a corrective action plan.

c) In the event a dispensing error (including near misses) occurs, Pharmacy shall report such dispensing error to Capital Rx within twenty-four (24) hours of becoming aware of such error. The report must include all relevant information including any corrective actions taken as well as any known outcomes and any evidence requested of it regarding the corrective actions. Capital Rx reserves the right to take any remedial action it deems appropriate if Member health or safety was, is or may be in the future at risk as a result of such error.

10) Confidentiality

a) Pharmacy understands that the following items of Capital Rx are proprietary and confidential and therefore agrees to keep such items confidential unless prohibited by applicable law.

i) The Agreement, any related Addenda, Exhibits and other related documentation including pricing;

ii) Any and all methods of doing business, processes, procedures and programs;

iii) Any and all symbols, logos, trademarks, trade names, Marks, patents, inventions, copyrights, copyrightable material, trade secrets, personnel information, operating manuals, memoranda, work marketing programs, plans and strategies, operating Agreements, financial

information and strategies, and computer software and other related materials developed or used by Capital Rx; and

iv) If a switch operator is accessing any proprietary and/or confidential information of Capital Rx or Clients, Pharmacy shall restrict such switch operator from making any commercial use of that data.

b) Pharmacy shall allow Capital Rx and Plan Sponsors to use Pharmacy's name and information in directories and communications to Plans and Members.

11) HIPAA Compliance

Pharmacy shall ensure compliance with the requirements of the HIPAA Privacy Rule, the HIPAA Security Rule and the Health Information Technology for Economic and Clinical Health Act ("HITECH Act"), and any other applicable HIPAA Regulations in the performance of the Agreement.

Pharmacy will report, following discovery and without unreasonable delay, but in no event later than five (5) calendar days following discovery, any Breach or suspected Breach of Unsecured Protected Health Information as these terms are defined by HIPAA Rules. Upon Capital Rx's request, Pharmacy will perform a fact-based risk assessment, as required at 45 CFR 164.410, to determine whether there is a low probability of compromise of PHI resulting from a Breach. If notification to the media or DHHS is required pursuant to HIPAA Rules, Pharmacy shall be responsible for any and all costs relating to such notice. Pharmacy shall cooperate with Capital Rx in investigating the Breach and in meeting Capital Rx's contractual obligations and obligations under HIPAA Rules and any other security breach notification laws.

Pharmacy will further require any of its subcontractors and agents to provide reasonable assurance evidenced by a written contract that such subcontractor or agent will comply with the same privacy and security safeguard obligations applicable to Pharmacy.

12) Audit

a) Audit Generally

Capital Rx has an audit program in place to ensure that each Pharmacy and the claims submitted to it are proper, clean and in compliance with applicable law, regulations, the Agreement and this Provider Manual. Capital Rx's audit program is meant to monitor claim activity so as to detect and prevent fraud, waste and abuse and/or errors in billing. Accordingly, all claims submitted to Capital Rx are subject to audit and Capital Rx may observe and photograph as necessary applicable facility operations and conditions.

b) Capital Rx or its authorized agent, governmental agencies or their representatives, ("Auditor(s)"), shall have the right to audit Pharmacy's books, records, signature logs, files, purchase invoices from a NABP accredited wholesaler, distributor or manufacturer, drug pedigree information, drug utilization review reports, equipment, compliance documents or records, pharmacy policy and procedures, and the respective facilities of all transactions which relate to any aspect of Pharmacy's performance of the Agreement or requirements of law during normal business hours and typically with reasonable notice of at least thirty (30) days for onsite audits or such longer or shorter period of time as required by applicable law unless Capital Rx reasonably believes that Pharmacy has engaged in fraudulent, wasteful or abusive activities in which case Capital Rx may conduct an audit without notice to Pharmacy unless prohibited by applicable law. All distributor purchase summaries or invoices of each wholesaler/distributor must come directly from the

wholesaler/distributor. Summaries or invoices received from the Pharmacy will not be accepted. Audits may occur via a phone call, on-site visit, desktop audit or through a Client-directed, regulatory investigative and/or compliance review. An Auditor may request an extension of an audit in which case Pharmacy shall accommodate such extension.

In addition, Capital Rx shall have the right to perform a facility review with or without notice to ensure Pharmacy's location(s) are in compliance. Facility reviews may include but are not limited to review, as well as documentation of all applicable licensures, proof of identification of employees, compliance with all federal and/or state regulatory requirements, proof of compliance with return to stock policy (which must be fourteen (14) calendar days or fewer from the date Claims are submitted to Capital Rx) various other reviews and inquiries to assure that overall quality assurance measures are implemented.

Pharmacy shall cooperate with the Auditors and promptly provide access to all information or documents as requested by the Auditors in a safe and secure manner. The Auditors may reproduce any record at its own expense; however, no original copy may be removed from Pharmacy's facilities. The Auditor may report its audit findings to Clients, appropriate governmental entities, regulatory agencies and professional review and audit organizations. If Auditors are denied access to any requested audit documents, Capital Rx may request Pharmacy to reimburse it for the total amount previously paid for such questionable Claim(s) immediately. Audits will be conducted in accordance with applicable laws and state regulatory guidelines. If additional language is required to be included in the Agreement or this Provider Manual by such applicable laws, such language shall be deemed included for the term of the Agreement and a period of five (5) years thereafter or such other time period in accordance with applicable law. Pharmacy shall reimburse Capital Rx for any discrepant Claims found during an audit. Such audit recovery amounts may be deducted from future remittances to Pharmacy or Pharmacy shall have thirty (30) days from the date of the Final Audit Report to reimburse Capital Rx for such recovery amounts.

In addition and subject to applicable law, depending on the nature of the discrepancies discovered in an audit, Capital Rx reserves the right to assess a penalty equal to the entire amount of the Claim for each violation, suspend or terminate Pharmacy or any of its locations from any or all Network(s), suspend Claims payment to Pharmacy for an indefinite period of time on behalf of any or all Plan Sponsors (including but not limited to any government authority, direction by subpoena, non-response to an audit request) pending the outcome of an audit and/or reasonable belief that Pharmacy is engaged in fraudulent or illegal activity or pursue other disciplinary or remedial action it deems necessary in its sole discretion.

In the event Capital Rx determines in its sole discretion that the cumulative errors or discrepancies rise to the level of fraud, waste or abuse or negligence, Capital Rx shall have the right to use extrapolation where permitted by law in the audit subject to applicable law or government entity. Below are some examples that Capital Rx may deem to rise to the level of fraud, waste or abuse or negligence. This list is not meant to be all inclusive and Capital Rx reserves the right to deem that other actions rise to the level of fraud, waste or abuse or negligence.

i) Billing for a Brand Drug Product and dispensing a Generic Drug Product;
ii) Billing of an NDC that is not what was dispensed;
iii) Overbilling of quantity prescribed;
iv) Undocumented substitution;
v) Non-covered item billed as covered;
vi) Duplicate Claim billed;

vii) Billing for more medication or drug product than dispensed (i.e., pill shorting);
viii) Submitting Claims for drug products that were not prescribed;
ix) Submitting dummy DEA/NPI or invalid DEA/NPI numbers to obtain a paid response;
x) Submitting claims for providers who have been sanctioned by CMS or who do not have a license to prescribe;
xi) Submitting Claims for more fills or refills than were authorized or illegal refill of a schedule II narcotic prescription;
xii) Billing for a Covered Prescription Service filled after the legal time limit has expired;
xiii) Billing for prescriptions which are invalid due to invalid/illegal prescriber, forgery, or false or fictitious documents including a provider who has lost his/her license to practice or does not have the proper credentials to prescribe;
xiv) Providing Covered Prescription services incorrectly based on the original order;
xv) Billing for Covered Prescription Services where a Member denies receiving the drug product(s) billed;
xvi) Billing for Covered Prescription Services where the prescriber denies prescribing the drug product(s) billed;
xvii) Covered Prescription Services returned to stock but not reversed;
xviii) Filling for prescriptions missing date written, or filled before date authorized;
xix) Filling for prescriptions missing prescriber signature;
xx) Filling for prescriptions missing any other information required by federal and/or state government authorities or law;
xxi) Filling for prescriptions that are illegal;
(1) Inappropriate, inaccurate or incomplete record-keeping practices related to billed prescriptions;
(2) Prescription splitting to obtain multiple dispensing fees or undermine prior authorization or quantity limits, etc.;
(3) Billing multiple lower strengths when one higher strength drug product is prescribed and available in the marketplace;
(4) Billing for a brand name Drug with DAW 1 when a Prescriber has not specified "Do Not Substitute" on the prescription, or other inappropriate use of DAW codes;
(5) Billing where pharmacy has not collected or has forgiven the member copay; and
xxii) Extreme excess in quantities or volumes of claims
(1) Billing of quantities or volumes of claims within a therapeutic category (topicals, dermatologicals, or other medications utilized in excess quantities for off-label utilization) as compared to other similarly situated pharmacies or plan sponsor formularies. Note that topical agents should have specific directions and the affected area to justify dispensing in larger quantities than a single package. To assist in determining if a quantity is sufficiently supported the FTU (fingertip-unit) chart can be used as a common reference.

c) Onsite Audits

i) For onsite audits, Pharmacy is required to:
(1) Have sufficient staff so as to be able to assist the Auditors in answering questions and/or gathering requested information;
(2) Not refuse an audit when the Auditors arrive at the prescheduled time and location;
(3) Provide the Auditors with a safe and secure space in which to work within the Pharmacy location that has the necessary elements the Auditors need (e.g., appropriate lighting, electrical outlets, etc.);
(4) Provide the Auditors with full access to all applicable records, files, logs and other relevant documentation as well as to the facilities themselves should the Auditors need to review any aspects of the facilities used to provide services to the Members (e.g., refrigeration, storage area, etc.);

(5) Provide the Auditors with the ability to observe the actual retrieval of the relevant records by Pharmacy personnel; and
(6) If applicable, provide the Auditors with a copy of any compound recipe identifying the ingredients used in a compounded prescription.

ii) For onsite audits, the Auditors:
(1) May request copies or take digital images of any of the applicable requested documents; and
(2) Will use reasonable efforts to minimize any disruption of Pharmacy's business while onsite.
(3) Will perform an exit interview to discuss the preliminary findings while onsite.

iii) Reporting Procedure for onsite audits:
(1) Pharmacy will receive a written disclosure of preliminary audit findings following the conclusion of the onsite audit. Initial audit findings will be sent to pharmacy within thirty (30) days of the audit.
(2) Pharmacy or Pharmacy's locations shall have the opportunity to dispute the initial audit findings by filing an appeal within thirty (30) days, or within such other timeframe mandated by applicable law, from Pharmacy or Pharmacy location's receipt of the initial audit findings letter. Such appeal must be sent via certified mail or other method that evidences tracking (FedEx, UPS, etc.), to the attention of the Capital Rx Audit Manager, or as otherwise instructed in the initial audit findings letter. Upon extenuating circumstances, a request for an extension may be granted at the sole discretion of Capital Rx. Capital Rx must receive Pharmacy's request for an extension within the required thirty (30) day timeframe or such other timeframe listed in the initial audit findings letter. In the event Pharmacy does not submit an appeal within the timeframe allowed, Pharmacy shall be deemed to have accepted the audit findings in the initial audit findings letter and any discrepant Claims shall be subject to recoupment.
(3) Any prescription documentation Pharmacy submits after the audit has concluded must be original hard copies or other original documentation approved by Capital Rx as verbal orders will not be accepted by Capital Rx. The original documentation must be on the prescriber's letterhead, as outlined in the initial audit findings letter, if the documentation is to substantiate an order whereby a prescription order could not be located in the pharmacy.
(4) Capital Rx or its Auditors may contact patients to verify an order (a) has been requested by the patient and (b) picked up by the patient or its authorized caregiver. If prescription cannot be validated by the patient, the claim will be reversed. If the pharmacy cannot validate that payment of the copay has been made through credit card or cash receipts, then the prescription will be reversed.
(5) Capital Rx or the Auditors will send Pharmacy its final audit findings following the conclusion of the dispute period, in accordance with any applicable state law, and with consideration of any dispute that was filed timely. The final audit findings will state if and whether full or partial recoupment is necessary or if the findings are for educational purposes.

d) Desk Audits

i) For desk audits, Pharmacy is required to:
(1) Submit copies of requested documentation, including any supporting information within thirty (30) days, or within such other timeframe mandated by applicable law;

ii) Documentation requested generally may include, but is not limited to the following:
(1) Copies of the original prescription order, front and back (if applicable);
(2) Back-tag", prescription label, or other computer-generated information that shows how the pharmacy billed the claim under review;

(3) Signature or delivery logs documenting receipt of medication within fourteen (14) days from submission of claim;
(4) Documentation to support delivery of claims via mail such as tracking numbers that are linked to prescription numbers within the pharmacy system;
(5) Proof of copayment collection;
(6) Electronic, time stamped notes, if applicable;
(7) Compounding logs and supporting records, if applicable;
(8) Current Compliance, License, and Insurance documentation, including any attestations of compliance with state or federal statutes, regulations, or CMS guidance.

iii) For desk audits, Auditor will:
(1) Send notification via email, fax, or mail directly to pharmacy or as required by provider agreement directly to PSAO;
(2) Send a copy of the initial audit findings with claim level details after reviewing the submitted documentation or expiration of response window for audit;
(3) Provide pharmacy a copy of the final audit findings after the appeal is reviewed that will include claim information or a notice of no findings indicating no recovery will be made.

iv) Reporting Procedure for desk audits:
(1) Pharmacy will receive via fax, email, or mail a copy of the initial findings within sixty (60) days of receipt of desk audit records.
(2) Pharmacy or Pharmacy's locations shall have the opportunity to dispute the initial audit findings by filing an appeal within thirty (30) days, or within such other timeframe mandated by applicable law, from Pharmacy or Pharmacy location's receipt of the initial audit findings letter. Such appeal must be sent via certified mail or other method that evidences tracking (FedEx, UPS, etc.), to the attention of the Capital Rx Audit Manager, or as otherwise instructed in the initial audit findings letter. Upon extenuating circumstances, a request for an extension may be granted at the sole discretion of Capital Rx. Capital Rx must receive Pharmacy's request for an extension within the required thirty (30) day timeframe or such other timeframe listed in the initial audit findings letter. In the event Pharmacy does not submit an appeal within the timeframe allowed, Pharmacy shall be deemed to have accepted the audit findings in the initial audit findings letter and any discrepant Claims shall be subject to recoupment.
(3) Any prescription documentation Pharmacy submits after the audit has concluded must be original hard copies or other original documentation approved by Capital Rx as verbal orders will not be accepted by Capital Rx. The original documentation must be on the prescriber's letterhead, as outlined in the initial audit findings letter, if the documentation is to substantiate an order whereby a prescription order could not be located in the pharmacy.
(4) Capital Rx or the Auditors will send Pharmacy its final audit findings following the conclusion of the dispute period, in accordance with any applicable state law, and with consideration of any dispute that was filed timely. The final audit findings, with claim level detail, will state if and whether full or partial recoupment is necessary or if the findings are for educational purposes.

e) Audit Reporting and Dispute Process

With the exception of telephone audits, the Auditors shall notify Pharmacy in writing of the audit findings based on the documentation provided to the Auditors ("Initial Audit Report"). Pharmacy shall have thirty (30) days, or such other amount of time as mandated by applicable law, from the date of the Initial Audit Report to provide supplemental information which shall be reviewed, and the Auditors shall determine whether such information is acceptable. Except for telephone audits, based on Pharmacy's response to the Initial Audit Report, the Auditor's shall issue a Final Audit Report which

shall include the final findings, remaining audit discrepancies, methods used to calculate such discrepancies, and any payments due to Capital Rx. In the event Capital Rx or the Auditors in their sole discretion finds that any errors or audit discrepancies are material, Pharmacy shall pay to Capital Rx all reasonable costs incurred in connection with the audit, including costs and expenses incurred to identify and correct such errors and/or discrepancies.

In the event pharmacy wishes to dispute the Final Audit Report it must be postmarked within thirty (30) days in writing to the following address with an electronic mail copy to pharmacy_audit@cap-rx.com:

Capital Rx
ATTN: Pharmacy Audit Department
228 Park Ave. S, Suite 87234
New York, NY 10003

The letter should include pharmacy information, each claim in dispute with prescription number, date of fill, and supporting documentation to justify the disputed claims.

Note that if the pharmacy being audited is affiliated with a PSAO, Capital Rx may decide to notify the Pharmacy's PSAO of the audit findings.

State Specific Requirements New Mexico: To the extent required by N.M. Stat. Ann. § 61-11-18.2(8), an audit of the records of a Pharmacy by Capital Rx shall not exceed two years from the date the claim was submitted to or adjudicated by Capital Rx, unless it conflicts with state or federal law.

State Specific Requirements Iowa: Pharmacy shall have the right to request an independent third-party review related to audit findings.

f) Payment Withholding

In the event that Capital Rx suspects fraud, waste, or abuse ("FWA") by the Pharmacy, Capital Rx may suspend future payments to the respective Pharmacy until Capital Rx conducts and finalized its investigation.

13) Termination/Suspension

Capital Rx reserves the right to (i) immediately terminate or suspend the Agreement and/or any exhibit in place between Pharmacy and Capital Rx or (ii) immediately terminate or suspend Pharmacy or any of its individual locations from participation in its Networks pursuant to Client direction or specific network design, business needs or for cause including for any of the reasons listed below:

a. Engaging in actions, conduct or communication detrimental or disparaging to any or all Networks or Plans;
b. Engaging in actions that are reasonably believed to be fraudulent or in violation of any applicable federal, state or local law or regulation;
c. Rejecting Members at the point of sale for any non-clinical reason;
d. Implementing a block of any Plan or other systematic action that results in the blocking of a Plan and/or its Members;
e. Implementing any automated reversal process;

f. Attempting to redirect or steer Members to a different plan or other coverage including discount cards or other customer discount programs that would not result in a savings or benefit to the Member unless otherwise allowed by applicable law;
g. Attempting to steer a Client or Plan to terminate its relationship with Capital Rx or enter into a direct agreement;
h. Attempting to circumvent any security measure in place at the point of sale;
i. Losing any required licensure or insurance coverage;
j. Engaging in any action that disparages Capital Rx, any of its Clients or Members;
k. Providing any substandard, inferior or otherwise contaminated product or service to a Member;
l. Engaging in prohibited mail fulfillment;
m. Violating any term, condition or obligation contained in the Agreement and/or related Exhibits or other documentation including this Provider Manual;
n. Failure to maintain required credentialing information;
o. Acting in violation of any applicable federal, state and/or local law, regulation or rule including those related to the compounding, sale, dispensation, storage, packaging or use of any Drug Product, device, products or supplies dispensed to Members;
p. Being listed on the OIG or GSA exclusion lists or being sanctioned under or expelled from participation in the Medicare, Medicaid or other government programs;
q. Having any of its or its pharmacist's licenses or permits required to perform services under the Agreement suspended or revoked; or
r. Affiliating (including without limitation gaining an ownership or controlling interest in the applicable pharmacy location, holding of the physical real estate of the applicable pharmacy location, establishing a consultant relationship with the applicable pharmacy location, or otherwise obscuring ownership links to the applicable pharmacy location) with a pharmacy that was terminated for any of the conditions outlined herein or due to fraud, waste and abuse.

In addition to the termination and suspension provisions outlined herein, Capital Rx reserves the right to terminate or suspend the Agreement, in accordance with the terms outlined in the particular Agreement by and between Pharmacy and Capital Rx, including any applicable notification time periods or such longer or shorter notification time periods as required by applicable Client, Plan, or law. If a particular Client, Plan or law requires a notification time period that is not the specific time period noted in the applicable Agreement, the Parties understand that the Agreement will not terminate until such other notification time period required by the Client, Plan or law has ended.

In the event Pharmacy and/or any of its pharmacy locations is terminated or suspended for cause pursuant to the terms herein or in the Agreement, such Pharmacy will be provided with written notice describing the reason(s) for such termination or suspension and an opportunity to appeal as outlined below. For purposes of clarity, the Parties understand that termination or suspension of Pharmacy shall not impact the obligations and rights of the Parties with respect to transactions that occurred prior to the effective date of termination or suspension.

If termination is to the entire Agreement and all Networks, Capital Rx shall make an accounting of all monies due to Pharmacy and owed from Pharmacy and shall provide such information to Pharmacy within sixty (60) sixty days following the termination effective date. Pharmacy and Capital Rx shall pay each other any required amounts due to the other within thirty (30) days of finalization and receipt of such accounting information.

Capital Rx reserves the right to notify Clients, Plan Sponsors and/or Members regarding any termination, suspension or revocation and Pharmacy agrees to cooperate with Capital Rx and/or Plan Sponsors including assisting with transferring prescriptions.

Notwithstanding anything to the contrary, Capital Rx reserves the right to create custom networks at any time during the term of the Agreement that may or may not include all or some of Pharmacy's locations. at any time during the term of the Agreement.

The termination or suspension of the Agreement or a Network as to any particular Pharmacy location shall not prevent the subsequent termination or suspension of the Agreement or a Network as to any other Pharmacy location or of the Agreement in its entirety.

In the event Pharmacy is terminated or suspended and wants to appeal the termination or suspension, such Pharmacy may submit an appeal or information outlined below or in the applicable termination or suspension letter it received.

a. In the event Pharmacy is subject to termination, suspension or corrective action related to licensure sanctions, or ongoing government/state disbarment lists, no appeal is allowed. Pharmacy may obtain and submit information related to the incident, but the termination, suspension or corrective action will remain in place as outlined in the applicable termination, suspension or corrective action letter received by Pharmacy. Once all sanctions or debarments have been lifted, Pharmacy may reapply for network inclusion.
b. In the event Pharmacy is terminated or suspended due to breach of Capital Rx's policies or procedures, Provider Manual or the Agreement, Pharmacy has the right to submit related information for Capital Rx's review rebutting claims of breach within thirty (30) calendar days (or such longer period of time mandated by applicable law) of receipt of the termination or suspension letter.

** Note that Capital Rx reserves the right to report any suspected fraud, waste or abuse to the applicable Client, Plan Sponsor and/or appropriate authority such as the NBI MEDIC, U.S. District Attorney's Office or Office of Inspector General, the appropriate State Board of Pharmacy, and/or State Department of Insurance.

14) Pharmacy Complaint Process

All Pharmacy complaints cam be submitted in writing or phoned in to Capital Rx. The following information must be included as part of the complaint:

1. Reason for the complaint and documentation to support the complaint
2. Pharmacy NCPDP or NPI number
3. Prescription number
4. Date of service
5. Disputed prescription claim payment date(s) if applicable

The Capital Rx Provider Relations team is responsible for working towards a resolution of your complaint. To file a complaint, please send it to Capital Rx Provider Relations Team at provider.relations@cap-rx.com or call the Pharmacy Help Desk at 888-832-2779.

15) Pharmacy Dispute Process

Pharmacy and Capital Rx agree that they will attempt in good faith to resolve any dispute that may directly or indirectly arise out of or relate to the Agreement or this Provider Manual. If they are unable to resolve such dispute within thirty (30) calendar days after initial notice, each Party may, by notice to the other, have such dispute referred to a senior officer of each Party. Such officer shall attempt to resolve the

dispute by good faith negotiation within thirty (30) calendar days after receipt of such notice. If the designated officers are not able to resolve such dispute within such thirty (30) calendar-day period, then the dispute shall be submitted, upon the motion of either party, to arbitration to be conducted in accordance with the appropriate rules of the American Arbitration Association ("AAA") in New York. All such arbitration proceedings shall be administered by the AAA. The arbitration panel shall consist of three arbitrators. One arbitrator shall be appointed by each Party. The third arbitrator, who shall act as chairman of the arbitration panel, shall be appointed by the other two arbitrators. If any arbitration is commenced against any party hereto with respect to the subject matter contained in this Agreement, the Party prevailing in such arbitration shall be entitled, in addition to such other relief as may be granted in such proceeding, to a reasonable sum from the non-prevailing parties for attorney's fees, expenses, and costs in such arbitration, which sum shall be determined in such arbitration. The Parties agree that the decision of the arbitrators shall be final and binding as to each of them.

16) Rural Pharmacy Status

Capital Rx recognizes certain pharmacies as rural pharmacies if they are physically located more than fifteen (15) miles from another pharmacy's location, per the address on the NCPDP DataQ, irrespective of city, county and state lines. If Pharmacy is deemed to be rural, such Pharmacy must notify Capital Rx within thirty (30) days of their qualification changes.

III. Claims Processing

1) Bank Identification Number and Processor Control Number (BIN/PCN)

PROCESSOR	BIN	PCN	LINE OF BUSINESS
Capital Rx	610852	CHM, CAPLRX, *varies	Commercial
Capital Rx	610770	CAPLRX, *varies	Commercial
Capital Rx	024730	GBHRX, *varies	Commercial
Capital Rx	610770	CRXMD, CRXMB, *varies	Medicare
Capital Rx	610744	CRXMC, *varies	Medicaid

** PCN can vary by client. Please refer to the member identification card when processing claims.

Capital Rx pharmacy payer sheets are located on the Pharmacist Resources page, https://www.cap-rx.com/providers/pharmacist

2) Claims Submission Generally

Pharmacies must follow all NCPDP processing standards when submitting or reversal Claims. Pharmacies shall accept valid prescriptions either by hard copy, fax, ePrescription, pharmacy to pharmacy transfers, or prescriber call, where allowed by state and federal guidelines. Capital Rx encourages pharmacies to submit Claims electronically, but if the POS System is not operating

properly or Pharmacy is otherwise unable to submit Claims via the POS System, paper claims will be accepted. Claims may be submitted in the following standard formats:

a) POS System: NCPDP Version D.0 (or the most recent NCPDP standard);
b) Paper: Universal Claim Form (D.0 UCF). All paper Claims must be submitted on a Universal Claim Form (UCF, version PUCF_D02PT) to the following address unless otherwise noted on the Member's ID card or other Plan documentation provided by the Member. Information regarding the UCF is available at http://www.ncpdp.org/products.aspx
    i) **Capital Rx**
    Attn: Claims Department
    228 Park Ave S, Suite 87234
    New York, NY 10003

In addition, the Pharmacy is required to submit the appropriate PRC and PST code with each Claim in accordance with NCPDP standards and CMS requirements as applicable. Failure to do so may result in audit, recoupment of Claim payment or termination or suspension of the Agreement.

** Note that Pharmacy's acceptance of payment/reimbursement for a Claim is considered Pharmacy's consent and acceptance of the terms associated with such Claim including those outlined in the Agreement and this Provider Manual.

3) Claims Submission Medicare Part D

Per CMS requirements, and/or state regulatory requirements, Pharmacies must submit Claims to the Medicare Part D Sponsor or its intermediary whenever the ID card is presented or on file at the pharmacy, unless the Member expressly requests that a particular Claim not be submitted to the Medicare Part D Sponsor or its intermediary. Member may also present their ID card using an electronic device such as a phone or a tablet and may also have processing information included on an electronic prescription.

Unless a Medicare Member specifically requests that the claim not be submitted to their Medicare Plan, Network Pharmacy providers should refrain from collecting cash for claims that have, or could have been, adjudicated at POS and/or Medicare Part B copays that should be billed to Medicaid.

4) POS System

Capital Rx uses a POS System to adjudicate claims electronically and communicate certain information to Pharmacy location(s) real-time online. Pharmacy is encouraged to confirm their software vendor or proprietary system used by their location(s) are able to accept the messaging provided by the POS system. Below are examples of the type of Claims that can be adjudicated, and the type of information Capital Rx may communicate via the POS System.

a) **Claim types supported by the POS System**
    i) B1: Original Claims Adjudication - This transaction type captures and processes the Claim and returns the dollar amount allowed under the Plan's reimbursement formula. The B1 transaction is the prevalent transaction used by pharmacies.
    ii) B2: Claims Reversal - This transaction is used by a pharmacy to cancel a claim that was previously processed. To submit a reversal, a pharmacy must void a claim that has received a PAID status and select the REVERSAL (Void) option in its computer system.

iii) B3: Claims Rebill - This transaction is used by the pharmacy to adjust and resubmit a claim that has received a PAID status. A "claim re-bill" voids the original claim and resubmits the claim within a single transaction. The B3 claim is identical in format to the B1 claim with the only difference being that the transaction code (Field # 1v˜3) is equal to B3.
iv) E1: Eligibility inquiry – This transaction allows the pharmacy to determine eligibility.

** Note that for B2 Claims Reversal and B3 Claims Rebill, the Service Provider ID (NPI Number), prescription number, date of service (date the Claim was filled) and National Drug Code (NDC) must match the original paid Claim to be successfully transmitted.

b) **Communication types supported by the POS System**
i) Plan eligibility (Note that Plan eligibility may change retroactively for government funded programs and due to updated Member information received by Capital Rx);
ii) Drug coverage;
iii) Dispensing limits; and
iv) Pricing and payment information.

5) Required Data Elements

Capital Rx's payer specifications are required to be set up with Pharmacy's software vendor or proprietary software system to ensure access to required fields and to process Claims. Claims are not processed without all of the required or mandatory data elements. Required fields are noted in the POS system with a "R", Mandatory fields are noted in the POS system with a "M", and Qualified Requirement fields are noted with a "RW" in the POS System. Descriptions of these are below. Note that Required or Mandatory fields may or may not be used in the adjudication process and fields that are not required at this time may be required in the future. If data are submitted in fields not required for processing as indicated by the payer specifications, the data are subject to valid format/valid value checks. Failure to pass those checks could result in claim denials.

CODE	DESCRIPTION
M	**MANDATORY** Designated as MANDATORY in accordance with the NCPDP Telecommunication Implementation Guide Version D.0. The fields must be sent if the segment is required for the transaction.
R	**REQUIRED** Fields with this designation according to this program's specifications must be sent if the segment is required for the transaction.
RW	**QUALIFIED REQUIREMENT** "Required when" the situations designated have qualifications for usage ("Required if x," "Not required if y").

Capital Rx uses NCPDP-defined request formats or segments in the transaction types it implements. A list of those are below.

Segments supported for B1, B2 and B3 Transaction Types

TRANSACTION TYPE CODES			
Segment	B1	B2	B3

Header	M	M	M
Patient	S	S	S
Insurance	M	S	M
Claim	M	M	M
Pharmacy Provider	S	N	S
Prescriber	M	S	M
COB/Other Payments	S	N	S
Worker's Comp.	S	N	S
DUR/PPS	S	S	S
Pricing	M	S	M
Coupon	S	N	S
Compound	S	N	S
Prior Authorizations	S	N	S
Clinical	S	N	S
Facility	S	N	S

M = Mandatory **S = Situational** **N = Not Used**

6) Payer Specification

Capital Rx has included a list of transaction types and their field requirements in Appendix A – Plan D.0 Payer Specifications. These specifications outline the transaction types and their segments, fields, field requirement indicators (mandatory, situational, optional), and values supported by Capital Rx

7) Claim Processing Edits

Once Pharmacy submits a Claim through the POS System, the POS System returns a response indicating the outcome of the Claim processing. Below are the possible responses that may be returned via the POS System.

a) **PAID:** This message occurs when the Claim passes all edits.
b) **REJECTED (or DENIED):** This message occurs when the Claim fails an edit. Pharmacies requiring assistance should call the Pharmacy Support Center at 888-832-2779.
c) **Duplicate Response:** In addition to the messages below, the submitted Claim may be deemed a duplicate if Pharmacy tries to submit a Claim that has already been adjudicated with some or all of the information included with the previously submitted Claim. If there is an exact match on the fields below, the result will be a duplicate response and the POS System will return an NCPDP Error Code # 83 – Duplicate Paid Claim to indicate a possible suspected duplicate.
    i) Same Patient/Member
    ii) Same Service Provider ID

iii) Same Date of Service
iv) Same Product/Service ID
v) Same Prescription/Service Reference Number
vi) Same Fill Number

** Note that there may be instances in which Pharmacy sends a transaction request through the POS System and the request is received and processed, but, due to communication issues or interruptions, the response is not received by Pharmacy. In these instances, Pharmacy should resubmit the transaction request. The POS System responds with the same information as the first response, but the transaction response is marked as duplicate

Patient Residence Code (PRC) and Pharmacy Service Type (PST) Requirements

In conjunction with the requirements from NCPDP, Capital Rx requires that all claims are submitted to the POS system with a Patient Residence Code (PRC– D.0 field 3844X) and Pharmacy Service Type (PST – D.0 field 147-U7). Please ensure that accurate and appropriate information is submitted on every Claim because the PRC and PST information is reported to CMS. Failure to submit the correct PRC or PST code on a Claim may result in audit or recoupment of Claim payment.

If your pharmacy is contracted for more than one service, please ensure claims are submitted with the appropriate PRC and PST codes for the services provided.

Below are valid codes for claims submission:

Patient Residence Code (PRC)	PRC Description
00	Not Specified
01	Home
03	Nursing Facility/Long Term Care
04	Assisted Living Facility
06	Group Home
09	Intermediate Care/Mentally Retarded
11	Hospice

Pharmacy Service Type (PST)	PST Description
01	Community/Retail Pharmacy services
02	Compounding Pharmacy services
03	Home Infusion Therapy services
04	Institutional Pharmacy services
05	LTC Pharmacy services
06	Mail Order Pharmacy services
07	Managed Care Organization Pharmacy services
08	Specialty Care Pharmacy services
99	Other

Note: Claims submitted without an appropriate PRC or PST code may be rejected with the following:

- U7 = Missing/Invalid Pharmacy Service Type
- 4X = Missing/Invalid Patient Residence

- 4Y = Patient Residence Value Not Supported
- 4Z = Place of Service Not Supported By Plan
- 50 = Non-Matched Pharmacy Nbr

Prescription Origin Code Claim Submission

Pharmacies are required to submit the correct Prescription Origin Code in conformance with the NCPDP and PBM requirements. Please submit one of the following data elements within Prescription Origin Code (419-DJ):
1 = Written
2 = Telephone
3 = Electronic
4 = Facsimile (Fax)
5 = Transfer

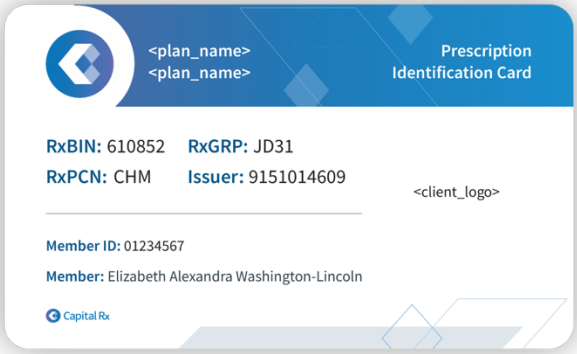
Claims submitted for a Prescription missing one (1) of these values will reject with the following NCPDP Reject Code 33 — "MISSING INVALID PRESCRIPTION ORIGIN CODE". If such a rejection occurs, please resubmit the Claim with the appropriate value.

8) Program Setup

Below is a list of the values required to set up the Plan programs along with sample ID cards.

FIELDS			DESCRIPTION	COMMENTS
BIN #				
Processor Control # (PCN#)				
Group			Plan	
Provider ID #			NPI	10 bytes (numeric)
Cardholder ID #			Plan Assigned Number	Up to 20 bytes (numeric)
Prescriber ID #			NPI number	10 bytes (numeric); an algorithm validation will be performed to verify NPI is valid
Product Code	National Drug Code (NDC)	11 digits		

Sample Identification Card



FRONT

BACK

9) Service and Support

a) Online Certification

The Software Vendor/Certification Number (NCPDP Field # 11Ø-AK) of the Transaction Header Segment is required for claims submission under NCPDP Version D.0. Capital Rx certifies software vendors, not an individual pharmacy's computer system. Pharmacy should contact its vendor or Capital Rx to determine if the required certification has been obtained. Pharmacy should submit the value that is assigned to them when being certified.

10) Technical Problems

In the event the POS System is unavailable, Pharmacy will receive one of the messages below.

NCPDP	MESSAGE	EXPLANATION
90	Host hung up	Host disconnected before session completed.
92	System Unavailable/Host Unavailable	Processing host did not accept transaction or did not respond within time out period.
93	Planned unavailable	Transmission occurred during scheduled downtime. Scheduled downtime for file maintenance is typically Saturday, 11:00 p.m., ET–Sunday, 6:00 a.m., ET.
99	Host processing error	Do not retransmit claims.

Capital Rx encourages Pharmacy to have software that has the ability to submit backdated Claims.

If Pharmacy receives a message indicating that its own network is having problems communicating with Capital Rx or if Pharmacy is experiencing other technical difficulties connecting with Capital Rx's POS System, Pharmacy should follow the steps below:

a) Check the terminal and communication equipment to ensure that electrical power and telephone services are operational.

b) Call the telephone number that the modem is dialing and note the information heard (i.e., fast busy, steady busy, recorded message).
c) Contact the applicable software vendor if unable to access this information in the system
d) If Pharmacy has an internal technical staff, forward the problem to that department, then the internal technical staff should contact the Capital Rx Pharmacy Help Desk
e) If unable to resolve the problem after following the steps outlined above, directly contact the Pharmacy Help Desk at 888-832-2779.

11) Claim Timely Filing Requirements

Capital Rx encourages Pharmacy to submit Claims electronically. If a Claim is submitted outside of the timeframes listed, the Claim may be denied with a NCPDP error code 81 "Timely Filing Exceeded". In the event Pharmacy needs to submit Claim(s) outside of the timeframes, Pharmacy may contact Pharmacy Help Desk at 888-832-2779.

a) **Initial Claim Submission**

Initial Claims are to be submitted within thirty (30) days from the date of fill unless otherwise agreed to in writing between Pharmacy and Capital Rx or otherwise mandated by applicable law.

b) **Reversals and Resubmissions**

Claims reversals and resubmissions are to be submitted within thirty (30) days from the original date of fill unless otherwise agreed to in writing between Pharmacy and Capital Rx or otherwise mandated by applicable law.

If a prescription Claim is not picked up or received by the Member within fourteen (14) days after the initial Claim submission, it must be reversed.

c) **Refill Messages**
   i) DEA = 0: Original plus up to 99 refills within 366 days from the original date on which the prescription was written
   ii) DEA= 2: No refills
   iii) DEA = 3–5: Original plus 5 refills within 183 days from original date on which the prescription was written

12) Schedule II Drugs

According to the to the Comprehensive Addiction Recovery Act 2016 (CARA), Pharmacy may fill a partial fill of a Schedule II Prescription Drug under the circumstances outlined below:

a) The partial fill it is not prohibited by state law;

b) The prescription is written and filled in accordance with federal and state law;

c) The partial fill is requested by the Member or the practitioner who wrote the prescription; and

d) The total quantity dispensed of the sum of all partial fills does not exceed the total quantity prescribed.

Remaining portions of a partially filled prescription for a Schedule II controlled substance may be filled no later than thirty (30) days after the date on which the prescription was written. Per 21 CFR § 1306.11, Schedule II Prescription Drugs may not be dispensed without a prescriber's written prescription except in emergency situations or when dispensed directly by a prescriber other than a pharmacist to the end user of the Schedule II Prescription Drug. If partial fill was for an emergency oral Schedule II Prescription Drug, Pharmacy must fill the remaining amount within seventy-two (72) hours of the date of the first partial fill. Pharmacy must receive a new prescription to dispense any additional quantity after the seventy-two (72) hour window has expired.

In addition, Pharmacy must comply with applicable state and federal laws and regulations governing the dispensing (including partial dispensing) of Schedule II Prescription Drugs.

13) Generic Drug Programs

A Plan may have a mandatory Generic Drug program in place in which either:

a) Multi-Source Brand products submitted with a DAW code of '1,' Physician requested brand be dispensed (Physician writes "Dispense as Written" on the prescription when there is a generic equivalent available) may require a medical exception review to bypass the pricing. Member may have to pay the cost difference between the Brand Drug rate versus the Generic Drug rate, plan option; or

b) Multi-Source Brand products submitted with a DAW code of '2,' Member requests brand be dispensed. In addition, this scenario may require a prior authorization to bypass the pricing. Member may have to pay the cost difference between the Brand Drug rate versus the Generic Drug rate, plan option.

** Note that exceptions to these programs may exist.

14) Dispensing Limits and Claim Restriction

A Plan may have certain dispensing limits or Claim restrictions in place that may result in point-of-sale rejections if Claims are submitted outside of such limits or restrictions. Please review the Claim reject responses and contact the Pharmacy Support Center (888) 832-2779as necessary.

a) Days' Supply

Plans determine their standard days' supply limits and may allow up to a one hundred two (102) retail day supply. Pharmacy must participate in the applicable extended day retail network in order to fill Claims with that retail day supply. Please contact the Pharmacy Support Center at (888) 832-2779if a days' supply rejection is received or contact the Pharmacy Relations team at Capital Rx to request a contract for participation.

b) Quantity, Dollar, Age and Other Limits

Plans determine their own quantity (minimum or maximum quantity limits, quantity per day and over time, maximum daily dose), dollar and age (minimum and maximum age), and other limits. Please refer to the rejection response received or contact the Pharmacy Support Center at (888) 832-2779if assistance is needed.

15) Reimbursement and Cost Sharing Amounts

a) Reimbursement Generally

Pharmacy's acceptance of a successfully adjudicated Claim constitutes its acknowledgment of participation in the applicable Network in which the Claim adjudicated and its acceptance of all corresponding terms and conditions, including the rates and reimbursements of Claims, for such Network. In addition, Pharmacy understands that Capital Rx may, at its option, decide to allow other pharmacy benefit or third-party administrators access to Capital Rx's networks and Pharmacy's acceptance of a successfully adjudicated Claim constitutes its acknowledgment and consent to participate in any such network. Capital Rx shall pay Pharmacy the Pharmacy Reimbursement Rates and Dispensing Fees as forth in the applicable Agreement, Network Exhibit, Provider Manual, or the on-line transaction response, less the applicable Cost Sharing Amount. Such Reimbursement Rates and Dispensing Fees may include compounding fees, Specialty Drug reimbursement or long-term care drug reimbursement and are subject to change or renegotiation between the Capital Rx and Pharmacy. Note that Pharmacy Reimbursement Rates and Dispensing Fees vary from Plan to Plan. The on-line transaction response pricing prevails, unless an overpayment is made to Pharmacy. Reimbursement is determined based on the NADAC price for the specific 11-digit NDC number for a particular Prescription Drug or, in the event there is no NADAC price for a Prescription Drug, the fallback logic pricing which may be AWP-based pricing, and paid at the lesser of: the Plan or Network specific Pharmacy Reimbursement Rates or other reference based or fallback logic pricing plus applicable Dispensing Fee, Pharmacy's submitted cost amount, or Pharmacy's U&C. The on-line transaction response pricing prevails, unless an overpayment is made to Pharmacy. Note that Capital Rx does not use any maximum allowable cost (MAC) pricing structures as part of its reimbursement models.

Capital Rx may make adjustments to recoup from Pharmacy overpayments made to Pharmacy or to address any errors in the POS System either via offsetting such overpayment amount from future payments to Pharmacy or requiring Pharmacy to remit payment to Capital Rx within thirty (30) days of notice of overpayment. Pharmacy acknowledges that it is obligated to review remittances received from Capital Rx to confirm accuracy and shall have thirty (30) days from receipt of a remittance to review and notify Capital Rx of any discrepancy. If Pharmacy does not notify Capital Rx of any discrepancy, Pharmacy will be deemed to have confirmed the accuracy of payments made by Capital Rx for Claims processed pursuant to such remittance.

Capital Rx discount cards can be identified by looking at the client ID on your Capital Rx pharmacy remittance advice. Discount card claims utilize the prefix CRA, VCX, PEN, RXPA, or RXPB. These claims may have up to a $1.99 administrative fee on non-U&C claims, which will show up as a negative plan pay amount. For clarity purposes, this is not a claw back and does not come out of the pharmacy's negotiated dispense fee. This administrative fee is collected by the pharmacy at the register as it is added to the total amount the patient owes for the discount card claim (NADAC + the Pharmacy's Dispense Fee + up to a $1.99 administrative fee). To collect this fee from the pharmacy, Capital Rx will invoice that amount or net it from other paid transactions.

Payment Rules under Medicare and Medicaid Programs

In accordance with requirements as set forth in 42 C.F.R §423.520(a)-§423.520(h) Pharmacy will be paid for Clean Claims as follows:

- For Medicare Part D, Clean Claims will be paid within fourteen (14) days after the date of receipt for electronic Claims and within thirty (30) days after receipt for paper Claims.

- Unless a particular state Medicaid agency requires a shorter time period, Medicaid Clean Claims will be paid within thirty (30) days of the Pharmacy's submission.

b) Electronic Fund Transfer (EFT)

For the pharmacy's convenience Capital Rx offers Electronic Fund Transfers. The pharmacy shall fill out the EFT form and provide the applicable documentation. Once the form has been completed and documents have been received by Capital Rx the EFT would be effective upon the next payment cycle.

c) Check Reissuance

Pharmacy paper checks are issued to the pharmacy mailing address registered with NCPDP. The cancelation of an issued check and reissuance of a replacement check is subject to a $10 per check fee (subject to change). Pharmacies are responsible with updating their mailing address with NCPDP of any address change. Pharmacies are subject to a $5 processing fee per check if pharmacy is requesting the replacement check to be issued to any address other than what is registered with NCPDP. A pharmacy must fill out the Check Reissue Request form located on the Capital Rx's website in order to receive a replacement check. A check must be outstanding for 30 days from the issue date before a reissuance request will be processed. Please allow up to three weeks for the original check to be cancelled and reissued. Check reissuance requests submitted in any manner other than the procedure described above may be subject to loss, processing delays, or rejection. To assure receipt by the proper department, the following email address should be used when submitting a check reissuance requests: ap@cap-rx.com.

d) Remittance Advice

For each check, Capital Rx provides an electronic remittance advice (ERA). Unless otherwise arranged with Capital Rx these reports are provided electronically through a Secure File Transfer Process (SFTP).

e) NADAC Unit Price Appeal

Capital Rx does not set the NADAC unit price. If the NADAC unit price is below the pharmacy acquisition cost, please follow the process CMS has set up for NADAC pricing concerns.

The NADAC Help Desk can be contacted through the following:
Toll-free phone: (855) 457-5264
Electronic mail: info@mslcrps.com
Facsimile: (844) 860-0236

f) Cost Sharing Amounts

Plans determine their own co-pay structure for all types of medications including by way of example only preferred Brand Drugs, non-preferred Brand Drug Products, Generic Drug Products, and Specialty Drugs. Please refer the Member to their own applicable Plan documentation, member portal, or the paid Claim response for applicable co-pay/Cost Sharing Amount information.

Notwithstanding anything to the contrary herein, PBM may include a Member service fee as an amount to be collected by the PHARMACY from the Member and remitted back to PBM on the applicable Claim(s). This fee does not impact the agreed upon Pharmacy Reimbursement Rate plus Dispensing Fee.

** Note that the Pharmacy Reimbursement Rate plus Dispensing Fee in addition to any Cost Sharing Amount for which a Member is responsible for based on their Plan, shall be considered full and final payment for the Covered Prescription Service rendered. Pharmacy may not seek any further payment

from Member, Capital Rx, or Plan regardless of the payment amount or whether such amount is less than Pharmacy's U&C. Pharmacy may not waive the Cost Sharing amount unless approved by Capital Rx or allowed by applicable law.

16) Tax

In the event a tax obligation applies, Pharmacy shall pay such tax unless Capital Rx or the Plan is required to reimburse or pay the tax in which case Capital Rx or the Plan shall pay the tax on behalf of the Pharmacy. In the event the applicable tax obligation is imposed on Capital Rx or the Plan and the Pharmacy seeks reimbursement that includes the tax amount, the Pharmacy must submit the correct tax amount information in the applicable field during Claim submission.

17) Coordination of Benefits

In the event a Member has other insurance coverage, Capital Rx reserves the right to administer coordination of benefits (COB) in accordance with the Plan design and applicable law and regulations. Pharmacy is required to verify with Members whether or not they have other primary or secondary insurance. Refer to the online transaction response as applicable for COB processing. Note that COB processing requires that the Other Payer Amount Paid, Other Payer ID, Other Payer Date, and Other Payer Patient Responsibility be submitted on the Claim to the Plan. Pharmacy must also submit the other insurance carrier code when coordinating claims for payment with a primary payer. In the event PBM processes copay assistance programs, the maximum amount PBM shall reimburse Pharmacy shall be the maximum amount allowed for the applicable copayment. If the copay assistance program does not cover the member's full copay amount, such other amounts shall be collected from the member by Pharmacy.

The following COB Other Coverage Codes will be accepted:

a) 0 – Not Specified: Submit when the Member does not specify other coverage.
b) 1 – No Other Coverage: This code is used when no other coverage is available.
c) 2 – Other Coverage Exists: Payment Approved. OCC 2 is used when any positive amount of money is approved from another payer. Submit the amount approved from the primary payer.
d) 3 – Other Coverage Exists: Claim Rejected. OCC 3 is used when the Member has other coverage, and the Claim was rejected as not covered.
e) 4 – Other Coverage Exists: No Payment Approved. OCC 4 is used when a Member's other coverage is active and there was no payment amount approved from the other insurer (i.e., the Member has not met their deductible obligation, the total cost of the claim is less than the patient's cost share requirement). OCC 4 should also be used if the total cost of the Claim is less than the Member's other insurance co-pay requirement and the primary insurance plan made no payment.

** Note: OCC code value 8 – Claim Billing for Patient Financial Responsibility Only is not allowed.

18) Prior Authorization

Pharmacy is required to follow the prior authorization (PA) procedures detailed below. Such procedures may require Pharmacy to a help desk.

a) **Clinical Prior Authorizations**

The Capital Rx Clinical Call Center will receive Prior Authorization (PA) requests for products that have clinical edits for clients that use the Capital Rx adjudication platform. PA request(s) are made by the

prescribing physician or the prescribing physician's agent. Requests may be initiated by telephone, fax, or mail.

b) **Emergency Protocols**

The Plan may pay for a 72-hour emergency supply of medications that require a clinical PA (formulary edits do not qualify) if a PA request has not been processed and it is after hours, a weekend, or a designated holiday. An example of when this may occur is when the prescriber is unavailable to provide sufficient information required to complete the prior authorization.

i) The appropriate PA process must be utilized during regular business hours. All of the following conditions must be met for an emergency supply:
   - The participant is Plan-eligible on the date of service.
   - The medication requires clinical PA (Formulary edits do not qualify).
   - The medication is not an excluded product for the Plan.
   - The days' supply for the emergency period does not exceed three days.

ii) Emergency Supply Override Process
   - Claim denied for requiring a clinical PA. Non-formulary medications do not qualify.
   - The dispensing pharmacist should determine if an immediate threat of severe adverse consequences exist should the patient not receive an emergency supply.
   - In the dispensing pharmacist's judgment, if the dispensing of an emergency supply is warranted, determine the appropriate amount for a three-day supply. For unbreakable packages, the full package can be dispensed.

c) **Preferred Drug List (PDL)/PA/Quantity/Duration Lists**

i) All claims are interrogated against the Preferred Drug List (PDL), benefit requirements, and DUR criteria.

ii) All claims are interrogated for compliance with state and federal requirements.

iii) Prescriptions must be dispensed pursuant to the orders of a physician or legally authorized prescriber. Any subsequent refills may be dispensed not more than one year from the date the prescription was written (or earlier whenever legally dictated).

iv) Schedule 2 drugs (CIIs) may not be refilled.

v) Controlled drugs other than CIIs may be refilled, pursuant to the order of a physician or legally authorized prescriber, up to five refills or six months, whichever comes first.

vi) Non-controlled drugs may be refilled, pursuant to the order of a physician or legally authorized prescriber, up to one year.

19) Drug Utilization Review

Pharmacy is required to follow the drug utilization review (DUR) procedures detailed below and/or communicated to it. Such procedures may require Pharmacy to contact a help desk.

a) **Prospective DUR Drug Utilization Review (PDUR)**

PDUR Management tools help manage a patient's therapy before the medication is dispensed. PDUR encompasses the detection, evaluation, and counseling components of pre- dispensing drug therapy screening. Capital Rx performs an assessment of its UM programs (e.g., prior authorization, step therapy, quantity limit) and exceptions (e.g., formulary, tier), using evidence-based criteria, for medical necessity, efficiency and/or appropriateness of a drug prior to dispensing. This helps to address situations in which potential drug problems may exist. PDUR is performed prior to dispensing assists the pharmacists to ensure that their patients receive the appropriate medications.

Concurrent Drug Utilization (CDUR) management is embedded electronically in the Capital Rx clinical decision support tool and adjudication system, JUDI. Prescriptions are screened at the point of adjudication for any potential drug-therapy opportunities for improvement. The intention is to improve the health and safety outcomes for members in real time. If a problem is identified, a message is available for the pharmacy to view and address the potential issue(s).

Because the PDUR / CDUR system examines claims from all participating pharmacies, drugs that interact or are affected by previously dispensed medications can be detected. Capital Rx recognizes that the pharmacists use their education and professional judgments in all aspects of dispensing.

i) Drug Utilization Review Edits
The following CDUR edits will deny for the Plan:

- Early Refill (ER)
  (a) Early Refill Tolerance: 75–85%

  For non-controlled products, the system will automatically check for an increase in dose and when an increase in dosage is detected, the system will not deny the current claim for early refill.

  (b) The Call Center may assist in overriding this reject if one of the following circumstances exists:
    (i) Dosage/Therapy change has occurred
    (ii) Patient is no longer taking the original dosage
    (iii) Dosage Time/Frequency Change has occurred
    (iv) Two strengths of the same drug are used to make strength of that medication not currently manufactured
  (c) If allowed under each client's Benefit Plan, pharmacies may use submission clarification code (SCC) 03 "Vacation Supply", 04 "Lost/Damaged Prescription", and 05 "Therapy Change" to override early refill rejects at point of sale for these situations.
- Step Therapy
- Quantity Limits
- Therapeutic Appropriateness
  (a) Prior authorizations require a pharmacist to review a member's medical information to verify the requested medication is appropriate to treat the member's condition
  (b) If a medication is not appropriate, the pharmacist reviewing the case will contact the prescriber to address any concerns
- Generic use
  (a) Formulary restrictions and prior authorizations help increase the use of generic medications
- Therapeutic interchange
  (a) Formulary restrictions and prior authorizations help increase the use of therapeutically appropriate substitutions
- Drug-disease contraindications
  (a) Prior authorizations require a pharmacist to review a member's medical information to verify the requested medication is appropriate to treat the member's condition
  (b) If a medication is not appropriate, the pharmacist reviewing the case will contact the prescriber to address any concerns
- Drug Dosage

(a) Prior authorizations and quantity limits will require a pharmacist to review a member's medical information to verify the requested medication dose and quantity is appropriate to treat the member's condition
(b) If a dosage or quantity is not appropriate, the pharmacist reviewing the case will contact the prescriber to address any concerns

- Duration of treatment
  (a) Medication approvals are granted for a time period defined in the prior authorization criteria. Extended treatment duration requires reapproval.
- Drug-age precautions
  (a) Age limits on access to drugs are driven by FDA recommendations
  (b) Medications with age restrictions are flagged
  (c) Min Age (in years): The patient filling the medication must be equal to or older than the number listed in the filled to fill the NDC
    (i) If the patient is younger than the Minimum Age listed for the NDC, when the claim processes, claim will reject
    (ii) Reject Code: R-60 Product/Service Not Covered for Patient Age
    (iii) Additional Message Info: "Field(s) possibly in error: 302-C2, 304-C4, 401-D1, 407-D7, 489-TE (Patient is too young.)"
  (d) Max Age (in years): The patient filling the medication must be younger than or equal to the number listed in the field to fill the NDC
    (i) If the patient is older than the Max age listed for the NDC, when the claim processes, claim will reject
    (ii) Reject Code: R-66 Patient Age Exceeds Maximum Age
    (iii) Additional Message Info: "Field(s) possibly in error: 302-C2, 303-C3, 304-C4, 306-C6 (Patient is too old.)"
  (e) Drug-gender precautions
    (i) When a member fills a medication that is limited to a Gender that does not match the member's gender, the claim should reject
      1. Reject Code: 61 Product/Service Not Covered for Patient Gender
    (ii) Medications with gender restrictions are flagged
  (f) Regulatory limitations
    (i) Limits are placed on medications in alignment with state and federal regulatory requirements, through the formulary and prior authorization criteria
    (ii) Non-FDA approved drugs are excluded during formulary development
  (g) Duplication of therapy
    (i) Duplicative drugs are drugs that share the same drug group, class, name, dosage form, and strength
  (h) Drug-drug or drug-allergy interaction
    (i) Capital Rx will use Medi-Span's Drug Therapy Monitoring System (DTMS) to generate concurrent DUR screening results. Medi-Span will provide monthly updates to Capital Rx
    (ii) Medi-span calculates persistence of ingredients in body and overlap in days supply to identify potential interactions
    (iii) Soft reject for major and moderate interactions only
      1. Reject CODE: 88 – "DUR Reject Error"
      2. Additional Message Info: "Drug-drug interaction [interacting drug]"
    (iv) To override a soft reject, pharmacist will be prompted to enter in one of the following in field 440-E5 Professional Service code:
      1. MR (Medication Review) or
      2. M0 (Prescriber consulted) or
      3. P0 (patient consulted)

(v) Drug contains known allergens, drug-alcohol and drug-food interactions
1. Additional Message Info: “Drug contains known allergens”
2. Additional Message Info: “Potential alcohol interactions”
3. Additional Message Info: “Potential food interactions”

ii) CDUR Overrides

The following are the NCPDP interactive Professional Service, Result of Service, Reason for Service, and Submission Clarification codes. These codes may be used to override CDUR denials at the POS, if allowed.

Problem/Conflict Type: The following override codes may be used by providers in any condition where a provider level override is allowed for CDUR denials.

PROFESSIONAL SERVICE CODES ALLOWED FOR SUBMISSION	**All codes are allowed for all conflict types.**
PROFESSIONAL SERVICE CODE/DESCRIPTION	**Select one:** • AS/Patient Assessment • CC/Coordination of Care • DE/Dosing Evaluation/ Determination • FE/Formulary Enforcement • GP/Generic Product Selection • M0/Prescriber Consulted • MA/Medication Administration • MR/Medication Review • PH/Patient Medication History • PM/Patient • Monitoring • P0/Patient Consulted • PE/Patient Education/Instruction • PT/Perform Laboratory Test • RO/Physician Consulted Other Source • RT/Recommended Laboratory Tests • SC/Self CareConsultation • SW/Literature Search/Review • TC/Payer/Processor Consulted • TH/Therapeutic Product Interchange
RESULT OF SERVICE CODES ALLOWED FOR SUBMISSION	All codes are allowed for all conflict types.
RESULT OF SERVICE CODE/DESCRIPTION	**Select one:** • 1A/filled as is, false positive • 1B/filled prescription as is • 1C/filled, with different dose • 1D/filled, different direction • 1E/filled, with different drug • 1F/filled, different quantity • 1G/filled, Prescriber approved • 1H/brand, -to- generic change • 1J/Rx-to OTC change • 1K/filled, different dosage form • 2A/ prescription not filled • 2B/not filled – direction clarified • 3A/ recommendation accepted • 3B/ recommendation not accepted • 3C/discontinued drug

	• 3D/regimen changed • 3E/therapy changed • 3F/therapy chg – cost inc accepted • 3G/drug therapy • unchanged • 3H/follow-up report • 3J/Patient referral • 3K/instructions understood • 3M/compliance aid provided • 3N/medication administered
REASON FOR SERVICE CODE	• ER • DD • TD • SX
SUBMISSION CLARIFICATION CODE/DESCRIPTION (LISTED AS REFERENCE ONLY, NOT REQUIRED ON CLAIMS)	Select one: • 01/No Override • 02/Other Override • 03/Vacation supply • 04/Lost prescription • 05/Therapy change • 06/Starter Dose • 07/Medically necessary

All PDUR/CDUR alert messages appear at the end of the claim's adjudication transmission.

iii) Retro Drug Utilization Review (RDUR)

Capital Rx's RDUR management program reviews a member's therapy after they receive their medication. The logic identifies and profiles members, pharmacy providers, prescribers, and disease states. The purpose is to identify members and/or practitioners whose drug therapy regimens may not conform to best practices as determined by disease state guidelines. All standard retrospective DUR (RDUR) programs adhere to current standards of drug-based screening elements for medications that have limited clinical documentation supporting combination use, carry high-risk warnings for concomitant drug therapy, identify overuse, identify underuse or sub-therapeutic dosing of medication, suggest possible fraud, and abuse potential or offer other opportunities to improve patient care. Program-specific historical data are used to identify trends of interest and variables that can be used as reliable predictors of subsequent outcomes.

Paid pharmacy claims are retrospectively analyzed to identify members and providers that require intervention. Identified members and providers will receive a letter in the mail informing them of potential issues identified based on pharmacy claims data. Issues that are addressed include:

Underutilization: Identifies untreated members with qualified diagnoses and helps members start and stay on the right drugs to help improve adherence and close gaps in care (ex: prescribing statins for members with diabetes).

Overutilization: Identifies and reduces improper or unnecessary drug use, including potential misuse and abuse and off- label use (ex: short-acting Beta Antagonist (SABA) with no controller)

Clinical abuse or misuse: Identify and reduce improper medication use which can lead to member harm (ex: opioid use with benzodiazepine or skeletal muscle relaxant).

Drug-pregnancy precautions: Identify and reduce improper medication use in pregnant patients which can lead to harm (ex: avoiding certain medications in members taking prenatal vitamins)

Following implementation of each retrospective drug utilization management program, Capital Rx performs a follow-up evaluation to determine if the desired outcome was achieved. In cases where information is required from the prescriber, all requested information from the prescriber is limited to the member's clinical status at the time of the retrospective review determination.

Criteria are revised as therapeutic problems are identified and/or eliminated and new drug products are released. The program promotes therapeutic appropriateness of medications by checking for, but not limited to, early refills, brand versus generic utilization, drug-to-drug interactions, and therapeutic duplication. These RDUR edits detect potential adverse drug consequences of incorrect drug utilization. The RDUR system additionally detects excessive use of medication and insufficient daily doses. This RDUR edit detects errors in dosage and duration and also monitors member compliance. Clinical abuse/misuse can be determined so that remedial strategies can be introduced to improve quality of care and conserve program funds.

20) Consumer Safety

Capital Rx continually monitors FDA recalls and safety-related market withdrawals. In the event of an FDA Class 1 and Class 2 recall and market withdrawals, utilization reports are used to identify affected members who have received the product within the last 6 months (unless otherwise stated in the ship dates within the FDA recall alert).

1. In the event of a product recall or safety-related market withdrawals, notifications are sent to impacted members, prescribers, and pharmacies and will include the product's NDC, expiration date, and lot number(s).

2. Pharmacies must have internal processes in place to handle drug recalls including, but not limited to, assisting patients with obtaining a replacement product if needed.

21) 340(B) Drug Program

Pharmacy shall promptly notify Capital Rx of its 340(B)-provider status in the event Pharmacy is or becomes a 340(B) provider and eligible to acquire Prescription Drugs from drug manufacturers or wholesalers at reduced prices for use by eligible Members under the Public Health Service Act, Section 340(B) program during the term in which it is a participating provider in Capital Rx's network(s). Accordingly, subject to applicable law the Parties agree and acknowledge that Capital Rx shall be entitled to modify the pricing and reimbursement terms in its Agreement with Pharmacy to the extent that Pharmacy is able to acquire Prescription Drugs through the 340(B) program.

For all applicable 340B Drug Products, Pharmacy must identify 340(B) claims as follows: In the field 420-DK (Submission Clarification Code), a value of 20 indicates the Pharmacy has determined the drug products submitted to Capital Rx was purchased pursuant to rights available under Section 340B of the Public Health Act of 1992 including sub-ceiling purchases authorized by Section 340B (a) (10) and those made through the Prime Vendor Program (Section 340B (a) (8)).

If Pharmacy is made aware of the 340(B)-eligibility status after the claim has been adjudicated, Pharmacy must reverse the original claim and resubmit the claim with the correct Submission Clarification Code value of 20.

22) Vaccine and Immunization Administration

Commercial and Medicaid

When your pharmacy administers vaccines for eligible plan Members, reimbursement is based upon the pharmacy's current contracted rates, whereas the dispensing fee should also be considered to include any administration fee.

Medicare Part D

To be reimbursed the contracted administration fee for Part D eligible vaccine products, the Pharmacy Provider must (i) submit a DUR/ PPS Code Counter of "1" and Professional Service Code of Medication Administration (MA) and (ii) submit the contracted fee in the incentive fee section of the claim.

23) Compounded Drugs

Capital Rx seeks to ensure that the pharmacies that provide compounded drug services to its Members have the proper equipment, environment and abide by all applicable laws or regulations. Toward that end, Capital Rx may require Pharmacy to complete additional credentialing in order to provide compounded drug services. Such credentialing requirements may include: accreditation requirements, testing for stability and sterility, an ethics management compliance review to include business operations, compliance with Anti-Kickback and Stark law, federal/state pharmacy law, defined allowable sales and marketing conduct, and an onsite credentialing review. Evidence of unsafe compounding practices may be reported to the State Board of Pharmacy, Food and Drug Administration (FDA) or applicable regulatory agency.

Covered compounded drugs shall be reimbursed in accordance with a Pharmacy's submitted Claim information subject to any contractual or Plan requirements. The submitted Claim information that may be included in the determination of the Prescription Drug Compensation may include but is not limited to: the final calculated allowable ingredient cost is based on the combined price of the individual covered drug ingredients and quantities in the compounded drug subject to the lesser of pricing as related to the total ingredient cost or U&C pricing submitted by the Pharmacy.

In addition, when covered by the Plan, the maximum reimbursement for the bulk chemical powders in compounded drugs containing raw ingredients packaged as bulk chemicals where an equivalent federal-legend drug is available in the marketplace will be the lesser of the Pharmacy's Prescription Drug Contracted Rate for each approved ingredient for the NDC utilized or for each approved ingredient based on the pricing of the equivalent federal-legend drug. All raw or bulk chemicals must be from FDA-registered chemical manufacturer facilities and wholesalers with distribution locations in the United States. Although required at this time, submitting the level of effort code may not result in any change in reimbursement on the compounded drug Claim.

In addition, Pharmacy shall adhere to the compounded drug guidelines outlined below:

a) Pharmacy shall not engage in price rolling practices. Price rolling is defined as the practice of submitting multiple Claims in order to obtain the highest reimbursement possible often by circumventing the standard Prior Authorization (PA) process. For example, the Pharmacy submits a Claim for a compounded drug and receives a rejection. At this point Pharmacy should seek a PA. If the Pharmacy instead decides to resubmit Claims of the same quantity but different U&C prices until a paid Claim response is received, the Pharmacy has engaged in price rolling.

b) Pharmacy may not attempt to attain reimbursement that is greater than the amount submitted when processing a Claim for a compounded drug. Pharmacy may not replace ingredients without authorization from the prescriber or new prescription. Compounded drug Claims should be submitted with the correct amount prescribed and with corresponding accurate quantities and days' supply calculations.
c) Any attempts to circumvent the PA process by altering the days' supply and keeping the same quantity or reducing the quantity and days' supply to receive a paid Claim are prohibited.
d) Pharmacy may not submit a Claim for a compounded drug that has an alternative commercially available equivalent Drug.
e) If Pharmacy uses tablets or capsules in a compounded drug (weight/weight compounds in which the weight of the tablet displaces the weight of the final product not applicable to other compounds such as weight/volume), Pharmacy must document the total weight of the tablets or capsules prior to adding them to the compound.
f) Note that reconstituted preparations such as powdered antibiotics mixed with water prior to dispensing are not considered compounded drugs.
g) Claims for single NDC pre-made compound or compound kits shall not be submitted as compounded drugs with a compound code.
h) Compounded drug claims must be submitted via the POS System using the appropriate compounding indicator code of "2" in field NCPDP D.0 406-D6 with each ingredient cost submitted by the particular quantity of the NDC and with the applicable Level of Effort (LOE) code in field 474-8E of the NCPDP D.0 format describing the amount of time/work required to produce the compounded drug.
i) Claims for compounded drugs may be subject to quantity limits, dollar thresholds or PA restrictions, or the exception process determined by the applicable Plan.
j) Pharmacy is responsible for using only approved ingredients in compounded drugs. Such ingredients need to be within accepted standards for strength, quantity and purity, and must have the appropriate labeling and packaging in accordance with good compounding practices, official standards and scientific information.
k) All federal legend drugs and raw or bulk chemicals submitted in the Claim for the compounded drug must be:
    i) Approved by the Food and Drug Administration (FDA) for safety and effectiveness;
    ii) Purchased from a FDA-registered wholesaler with distribution locations within the United States and point of origin from a FDA-registered manufacturer facility;
    iii) Available only by Prescription;
    iv) Used and sold in the United States; and
    v) Used for a medically accepted indication to treat a covered condition, illness or injury. Medically- accepted indication not only refers to the indication but also the route of administration of the compound.
l) Compounded drug exclusions include:
    i) Reconstitution of an oral antibiotic or similar product;
    ii) Raw bulk chemicals from a non-FDA registered manufacturer facility and wholesaler with locations within the US;
    iii) Charges for ancillary supplies, flavoring/sweeteners, equipment depreciation and/or labor are not eligible for reimbursement;
    iv) Ingredients with missing or invalid NDC numbers are not eligible for reimbursement;
    v) Mixing of water or saline solution to another Federal Legend Drug; and
    vi) Compounded drugs for office use by medical providers and not compounded for individual Members.
m) Multi-ingredient compounded drug Claim submission:
    i) Applies to all BIN numbers

ii) Single-ingredient compound billing will not be accepted as a compounded drug (submit a compounding code indicator of "1" in NCPDP D.0 field 406-D6)

iii) Each individual ingredient should be represented by the NDC of the product(s) used and dispensed, including:

- The total quantity of each specific ingredient
- The cost of each individual ingredient with basis of cost determination
- Up to twenty-five (25) ingredients may be entered for each Compounded Drug Claim

iv) Submit the NDC number in the Claim segment as "0" (zero) and the Product/Service Identification qualifier should be submitted as "00" (two zero's). Use the correct NCPDP compound segment to identify each individual ingredient.

n) Submit a compound code of 2 (two) in field 406-D6 in accordance with NCPDP standards as defined in the payer sheets for Version D.0.

o) Submit the quantity dispensed as the total metric quantity of the finished compounded drug, including:

i) Sum of all individual ingredient costs as the Pharmacy's "Ingredient Cost Submitted" for the compounded drug Claim

ii) Submit the Pharmacy's U&C for the compounded drug Claim

p) The final cost (calculated total cost/ingredient cost submitted) should be no greater than the combined NADAC or fallback cost as applicable of all ingredients and the U&C.

EXAMPLES OF COMPOUNDED DRUG CODES AND DESCRIPTIONS		
11	Compounded drug does not contain an active pharmaceutical bulk powder ingredient or excipient	Magic Mouthwash, combinations of manufactured dermatological creams/ointments
12	Compounded drug contains at least 1 active pharmaceutical bulk powder ingredient	Simple suspensions, dermatological preparations
13	Compounded drug requires pH adjustment for stability, use of liposomal bases, troches, rapid dissolve tablets, suppositories, capsules (any route of administration)	Transmission occurred during scheduled downtime. Scheduled downtime for file maintenance is typically Saturday, 11:00 p.m., ET–Sunday, 6:00 a.m., ET.
14	Compounded drug contains hazardous/controlled substances	Do not retransmit claims.
15	Sterile compounded drug - must be compounded in a <797> compliant environment and are dispensed as sterile finished preparation	Any sterile compounded drug

If a non-covered ingredient (such as bulk powders, invalid NDC's, plan exclusions, etc.) is submitted with a compounded Drug Claim, the Claim will reject and the POS System response will inform the Pharmacy

which ingredients were rejected. Pharmacy may resubmit the and the compounded Drug Claim with a Submission Clarification code of "08". The resubmitted compounded Drug Claim will adjudicate and the applicable network (including Medicare Part D network) reimbursement will exclude the non-covered ingredients. Note that Pharmacy may not charge the Member more than the Cost-Sharing Amount provided by the POS System, including for non-covered ingredients.

24) Basis of Cost Determination Field

So as to align with current NCPDP guidelines and applicable state requirements, pharmacies are required to submit a Basis of Cost Determination value of 15, indicating free product or no associated cost, when submitting an ingredient cost of $0.00 or $0.01.

a) If the Basis of Cost Determination field (423-DN) is left blank or submitted with any code other than 15 when the ingredient cost of $0.00 or $0.01 is submitted, the claim will reject with code: DN – M/I Basis of Cost Determination.
b) If a claim is submitted with Basis of Cost Determination of 15 and the submitted ingredient cost field (438-E3) is any amount other than $0.00 or $0.01, the claim will reject with code: 23- M/I Ingredient Cost Submitted.

Submitted Basis of Cost Determination (423-DN)	Submitted Ingredient Cost (438-E3)	Expected Result
15	$0.00 or $0.01	Claim will process
Left blank	$0.00 or $0.01	Claim will reject with code: DN – M/I Basis Cost Determntn
Code is not 15	$0.00 or $0.01	Claim will reject with code: DN – M/I Basis Cost Determntn
15	Any amount other than $0.00 or $0.01	Claim will reject with code: 23 – M/I Ingredient Cost Submitted

Appendix A

Legal/Regulatory Specific Information

Arkansas

The following State Exhibit sets forth certain state regulatory requirements that will apply only in the state of Arkansas.

1) **Pricing Appeals**
   For a pricing reimbursement appeal allowed under Arkansas law, pharmacies must complete and submit the pricing appeal form found on Capital Rx's website within thirty (30) business days following the applicable fill date on the Claim subject to the appeal. Capital Rx will review and resolve the appeal within thirty (30) business days after the completed pricing appeal form is received. If the pricing appeal is resolved in favor of the pharmacy, Capital Rx will update the pricing to at least the appealing pharmacy's submitted acquisition cost, will provide the pharmacy the NDC the change is based on, will allow the pharmacy to reverse and reprocess the Claim in question, and will make the adjustment applicable to all similarly situated pharmacies in Arkansas within the network. Please note that pharmacies are required to submit their pharmacy acquisition cost. If Capital Rx denies the pricing appeal, Capital Rx will provide pharmacy with the reason for the denial of the appeal, identify the NDC of a Prescription Drug which may be purchased by the pharmacy at a price at or below the price determined by Capital Rx, and will provide the name of the referenced national or regional pharmaceutical wholesaler operating in the state. Capital Rx reserves the right to request supporting documentation to validate drug acquisition cost provided by Network Pharmacy Provider. Pharmacy invoice cost information and pricing appeals may be submitted to Capital Rx at pricing.appeals@cap-rx.com.

Delaware State Exhibit

The following State Exhibit sets forth certain state regulatory requirements that will apply only in the state of Delaware.

1) **Audit Amendments to the Agreement**
   Any unilateral amendments sent to address changes to the audits or audit program sent by Capital Rx shall take effect sixty (60) days after dissemination to the pharmacies.

Iowa State Exhibit

The following State Exhibit sets forth certain state regulatory requirements that will apply only in the state of Iowa.

2) **Termination or Suspension of Pharmacy**
   A contract between a pharmacy benefits manager and a pharmacy shall include a provision describing notification procedures for contract termination. The contract shall require no less than 60 days' prior written notice by either party that wishes to terminate the contract.

Mississippi

The following State Exhibit sets forth certain state regulatory requirements that will apply only in the state of Mississippi.

1) **Pricing Appeals**

For a pricing reimbursement appeal allowed under Mississippi law, pharmacies must complete and submit the pricing appeal form found on Capital Rx's website within thirty (30) business days following the applicable fill date on the Claim subject to the appeal. Capital Rx will review and resolve the appeal within thirty (30) business days after the completed pricing appeal form is received. If the pricing appeal is resolved in favor of the pharmacy, Capital Rx will update the pricing to at least the appealing pharmacy's submitted acquisition cost, will provide the pharmacy the NDC the change is based on, will allow the pharmacy to reverse and reprocess the Claim in question, and will make the adjustment applicable to all similarly situated pharmacies in Arkansas within the network. Please note that pharmacies are required to submit their pharmacy acquisition cost. If Capital Rx denies the pricing appeal, Capital Rx will provide pharmacy with the reason for the denial of the appeal, identify the NDC of a Prescription Drug which may be purchased by the pharmacy at a price at or below the price determined by Capital Rx, and will provide the name of the referenced national or regional pharmaceutical wholesaler operating in the state. In the event the NDC provided by Capital Rx is not available from the appealing pharmacy's pharmaceutical wholesaler from whom it purchases the majority of prescription drugs for resale, then upon receipt of notification, Capital Rx will allow the pharmacy to submit a secondary pricing appeal for a previously denied pricing appeal. Capital Rx will review the secondary pricing appeal and will update the pricing to at least the appealing pharmacy's submitted acquisition cost and will allow the pharmacy to reverse and resubmit the appealed claim impacted by the inability to procure the NDC at a cost that is equal to or less than the previously challenged price.

Montana State Exhibit

The following State Exhibit sets forth certain state regulatory requirements that will apply only in the state of Montana.

1) **Definitions for Purposes of this Exhibit**

a) "Contract pharmacy" means a pharmacy operating under contract with a federally certified health entity to provide dispensing services to the federally certified health entity.

b) "Federally certified health entity" means a 340B covered entity as described in 42 U.S.C. 256b(a)(4).

c) "Maximum allowable cost list" means the list of drugs used by a pharmacy benefit manager that sets the maximum cost on which reimbursement to a network pharmacy or pharmacist is based.

d) "Pharmacist" means a person licensed by the state to engage in the practice of pharmacy pursuant to Title 37, chapter 7.

e) "Pharmacy" means an established location, either physical or electronic, that is licensed by the board of pharmacy pursuant to Title 37, chapter 7, and that has entered into a network contract with a pharmacy benefit manager, health insurance issuer, or plan sponsor.

f) "Pharmacy benefit manager" means a person who contracts with pharmacies on behalf of a health insurance issuer, third-party administrator, or plan sponsor to process claims for prescription drugs, provide retail network management for pharmacies or pharmacists, pay pharmacies or pharmacists for prescription drugs, or provide other prescription drug or device services.

g) "Pharmacy performance measurement entity" means:

i) the electronic quality improvement platform for plans and pharmacies; or
ii) an entity approved by the board of pharmacy provided for in 2-15-1733 as a nationally recognized and unbiased entity that assists pharmacies in improving performance measures.

h) "Prescription drug" means any drug that is required by federal law or regulation to be dispensed only by a prescription subject to section 353(b) of the Federal Food, Drug, and Cosmetic Act, 21 U.S.C. 301 et seq.
i) "Prescription drug order" has the meaning provided in 37-7-101.
j) "Reference pricing" means a calculation for the price of a pharmaceutical that uses the most current nationally recognized reference price or amount to set the reimbursement for prescription drugs and other products, supplies, and services covered by a network contract between a plan sponsor, health insurance issuer, or pharmacy benefit manager and a pharmacy or pharmacist.

2) General Terms and Conditions

a) Reference price list, price formulation, updating, and disclosure
   i) At the time of entering into a contract with a pharmacy and subsequently upon request, Capital Rx shall provide the pharmacy with the sources used to determine the reference used for reference pricing.
   ii) For reference pricing, Capital Rx shall:
      1) review and update no less than every 10 business days the price information for each drug, product, supply, or service for which reference pricing is used; and
      2) provide a process for each pharmacy to readily access the reference pricing specific to the Plan Sponsor.
   iii) Capital Rx shall not:
      1) prohibit a pharmacist from discussing reimbursement criteria with a covered person
      2) penalize a pharmacy or a pharmacist for disclosing the information described in subsection (2)(c)(i) to a covered person or for selling a more affordable alternative to a covered person; or
      3) require a pharmacy to charge or collect a copayment from a covered person that exceeds the total charges submitted by the network pharmacy.
b) Opt-out of reference pricing--notification
   i) A pharmacist or pharmacy in a network plan with a plan sponsor, health insurance issuer, or pharmacy benefit manager providing covered drugs on a reference pricing basis may decline to provide a brand-name drug, multisource generic drug, supply, or service if the reference pricing amount is less than the acquisition cost paid by the pharmacy or pharmacist.
   ii) If a pharmacist or pharmacy declines to provide the prescription or service under the conditions in subsection (2)(d), the pharmacy or pharmacist shall attempt to provide the customer with adequate information as to where the prescription for the drug, supply, or service may be filled.
   iii) A pharmacy or pharmacist who declines to provide the prescription or service as provided in subsection (2)(e) shall cooperate with any investigation and review of network adequacy.
c) Allowable and prohibited fees on pharmacies.
   i) Capital Rx shall not directly or indirectly charge or hold a pharmacy responsible for a fee related to a claim:
      1) if the fee is not apparent at the time the claim is processed;
      2) if the fee is not reported on the remittance advice of an adjudicated claim; or (c) after the initial claim is adjudicated.
   ii) Capital Rx shall not collect a performance-based fee from a pharmacy only if the pharmacy fails to meet the criteria established by a pharmacy performance measurement entity. The

fee may be applied only to the professional dispensing fee outlined in the contract with the pharmacy and may not be imposed on the cost of goods sold by a pharmacy.

iii) Only criteria established by a pharmacy performance measurement entity may be used to measure a pharmacy's performance for the purposes of this section.

d) Limitation on copayments
   i) A pharmacy benefit manager or third-party payer may not charge a patient a copayment that exceeds the cost of the prescription drug. If a patient pays a copayment, the dispensing provider or pharmacy may retain the adjudicated reimbursement and the pharmacy benefit manager or third-party payer may not alter the adjudicated reimbursement.

e) Rights of pharmacies
   i) Capital Rx shall not prohibit a pharmacist or pharmacy from:
      1) participating in a class-action lawsuit;
      2) disclosing to the plan sponsor or to the patient information regarding the adjudicated reimbursement paid to the pharmacy if the pharmacist or pharmacy complies with the requirements of the federal Health Insurance Portability and Accountability Act of 1996, 29 U.S.C. 1181 et seq.;
      3) providing relevant information to a patient about the patient's prescription drug order, including but not limited to the cost and clinical efficacy of a more affordable alternative drug if one is available;
      4) mailing or delivering a prescription drug to a patient as an ancillary service of a pharmacy if the practice is not prohibited under Title 37, chapter 7; or
      5) charging a shipping and handling fee to a patient who has asked that a prescription drug be mailed or delivered if the practice is not prohibited under Title 37, chapter 7.
   ii) Capital Rx shall not require pharmacy accreditation standards or recertification requirements inconsistent with, more stringent than, or in addition to federal and state requirements for licensure as a pharmacy in this state.
   iii) A pharmacist or pharmacy that belongs to a pharmacy services administrative organization may receive a copy of a contract the pharmacy services administrative organization entered into with a pharmacy benefit manager or third-party payer on the pharmacy's or pharmacist's behalf.
   iv) Capital Rx shall provide a pharmacy or pharmacist with the processor control number, bank identification number, and group number for each pharmacy network established or administered by a pharmacy benefit manager or third-party payer to enable the pharmacy to make an informed contracting decision.
   v) A pharmacy benefit manager shall:
      1) (i) offer a pharmacy an opportunity to renew an existing contract every 3 years, at a minimum; and (ii) allow a pharmacy to terminate a contract upon a 90-day notice to the pharmacy benefit manager.
      2) An addendum or amendment to an existing contract between a pharmacy benefit manager and a pharmacy is effective only upon signing of the addendum or amendment by both parties.
   vi) A pharmacy has a private right of action to enforce provisions of 33-22-175 through 33-22-177.

f) Contract coverage, nondiscrimination
   i) Capital Rx shall not include in a contract with a federally certified health entity provisions that allow:
      1) payment for a prescription drug to the federally certified health entity or a contract pharmacy at less than the state rate determined by surveys used to develop national average drug acquisition costs for the Centers for Medicare and Medicaid Services or, if a national average drug acquisition cost has not been calculated, a payment less than the wholesale acquisition cost described in 42 U.S.C. 1395w-3a(c)(6)(B); or

2) an additional fee or charge or other adjustment that is imposed only on the federally certified health entity or its contract pharmacy. Other adjustments under this subsection (1)(b) include but are not limited to payment of a lower dispensing fee or requiring an add-on payment.

ii) A patient eligible to receive drugs under an agreement covered by 42 U.S.C. 256b may not be discriminated against through conditions imposed on a federally certified health entity or its contract pharmacy through which the patient is eligible to receive drugs.

iii) If Capital Rx is found guilty of violating subsection (2)(f)(i) or (ii), the insurance commissioner shall impose a fine for each separate entity not to exceed $5,000 for each violation, subject to a maximum fine of no more than $100,000 in any year.

Nebraska State Exhibit

The following State Exhibit sets forth certain state regulatory requirements that will apply only in the state of Nebraska.

The provisions of this Exhibit apply as, and only to the extent, required by applicable Nebraska law, rule or regulation. By entering into this Exhibit, PHARMACY is not agreeing to comply with any provision not applicable to it under applicable Nebraska law, rule or regulation, and is not agreeing to expand the scope of any obligation beyond the scope to which it is subject under applicable Nebraska law, rule or regulation. The parties agree that any provision not required by Nebraska law, rule or regulation to be included herein shall not be binding on PHARMACY. To the extent the AGREEMENT includes terms more favorable to PHARMACY than those set forth below, PBM shall comply with the terms set forth below and the terms in the AGREEMENT unless doing so would be in violation of applicable law. To the extent a defined term is used herein, the definitions in the AGREEMENT shall apply unless the AGREEMENT's definition conflicts with the definition in Section 44-4603 of the Nebraska Insurance Code, in which case, the Insurance Code definition shall apply.

I. Gag Clauses Prohibited. (Neb. Rev. Stat. § 44-4606(1)-(3)). Nothing in the AGREEMENT shall be construed or interpreted to:

1. Prohibit or restrict PHARMACY from or penalize PHARMACY for disclosing to any MEMBER any health care information that the PHARMACY deems appropriate regarding:

   a) The nature of treatment, risks, or an alternative to such treatment;

   b) The availability of an alternate therapy, consultation, or test;

   c) The decision of a utilization reviewer or similar person to authorize or deny a service;

   d) The process that is used to authorize or deny a health care service or benefit; or

   e) Information on any financial incentive or structure used by PBM.

2. Prohibit PHARMACY from discussing information regarding the total cost for a pharmacist service for a prescription drug or from selling a more affordable alternative to the MEMBER if a more affordable alternative is available.

3. Prohibit, restrict, or limit PHARMACY's disclosure of information to the director, law enforcement, or a state or federal governmental official, provided that:

a) The recipient of the information represents that such recipient has the authority, to the extent provided by state or federal law, to maintain proprietary information as confidential; and

b) Prior to disclosure of information designated as confidential, PHARMACY:

i. Marks as confidential any document in which the information appears; or

ii. Requests confidential treatment for any oral communication of the information.

II. Limitation on Termination. (Neb. Rev. Stat. § 44-4606(4)) PBM shall not terminate the AGREEMENT due to PHARMACY:

1. Disclosing information about a PBM practice, except information determined to be a trade secret, as determined by state law or the Nebraska Director of Insurance; or

2. Sharing any portion of the AGREEMENT with the director pursuant to a complaint or a query regarding whether the contract is in compliance with the Pharmacy Benefit Manager Licensure and Regulation Act.

III. Member Cost-Sharing. (Neb. Rev. Stat. § 44-4606(4)).

1. Nothing in the AGREEMENT shall be construed or interpreted to require a MEMBER purchasing a covered prescription drug to pay an amount greater than the lesser of MEMBER's cost-sharing amount under the terms of the PLAN or the amount the MEMBER would pay for the drug if the MEMBER were paying the cash price.

2. Any amount paid by a MEMBER under section 3(a) shall be attributable toward any deductible or, to the extent consistent with section 2707 of the federal Public Health Service Act, 42 U.S.C. 300gg-6, as such section existed on January 1, 2022, the annual out-of-pocket maximum under the MEMBER's PLAN.

IV. Audits. (Neb. Rev. Stat. § 44-4607).

For purposes of this section, AUDITING ENTITY means or any person that represents PBM in conducting an audit for compliance with a contract between the PBM and PHARMACY. (Neb. Rev. State. § 44-4604).

1. Unless otherwise prohibited by federal law, an AUDITING ENTITY conducting a pharmacy audit shall:

a) Give PHARMACY notice fifteen business days prior to conducting an initial onsite audit;

b) For any audit that involves clinical or professional judgment, conduct such audit by or in consultation with a pharmacist; and

c) Audit PHARMACY under the same standards and parameters as other similarly situated pharmacies.

2. Unless otherwise prohibited by federal law, for any audit of PHARMACY conducted by an AUDITING ENTITY:

a) The period covered by the audit shall not exceed twenty-four months from the date that the claim was submitted to the AUDITING ENTITY, unless a longer period is required under state or federal law;

b) If AUDITING ENTITY uses random sampling as a method for selecting a set of claims for examination, the sample size shall be appropriate for a statistically reliable sample;

c) The AUDITING ENTITY shall provide PHARMACY a masked list containing any prescription number or date range that the AUDITING ENTITY is seeking to audit;

d) No onsite audit shall take place during the first five business days of the month without the consent of PHARMACY;

e) No auditor shall enter the area of PHARMACY where patient-specific information is available without being escorted by an employee of PHARMACY and, to the extent possible, each auditor shall remain out of the sight and hearing range of any PHARMACY customer;

f) No recoupment shall be deducted from or applied against a future remittance until after the appeal process is complete and both parties receive the results of the final audit;

g) PBM shall not require information to be written on a prescription unless such information is required to be written on the prescription by state or federal law;

h) Recoupment may be assessed for information not written on a prescription if:

i. (A) Such information is required in the provider manual; or (B) the information is required by the federal Food and Drug Administration or the drug manufacturer's product safety program; and

ii. The information required under subsection (i)(A) or (B) of this subsection (h) is not readily available for the AUDITING ENTITY at the time of the audit; and

i) No AUDITING ENTITY or agent shall receive payment based on a percentage of any recoupment.

3. For recoupment under the Pharmacy Benefit Manager Licensure and Regulation Act, the AUDITING ENTITY shall:

a) Include consumer-oriented parameters based on manufacturer listings in the audit parameters;

b) Consider PHARMACY's usual and customary price for a compounded medication as the reimbursable cost, unless the pricing method is outlined in the AGREEMENT;

c) Base a finding of overpayment or underpayment on the actual overpayment or underpayment and not a projection that relies on the number of patients served who have a similar diagnosis, the number of similar orders, or the number of refills for similar drugs;

d) Not use extrapolation to calculate the recoupment or penalties unless required by state or federal law;

e) Not include a dispensing fee in the calculation of an overpayment, unless a prescription was not actually dispensed, the prescriber denied authorization, the prescription dispensed was a medication error by PHARMACY, or the identified overpayment is solely based on an extra dispensing fee;

f) Not consider as fraud any clerical or record-keeping error, such as a typographical error, scrivener's error, or computer error regarding a required document or record. Such error may be subject to recoupment;

g) Not assess any recoupment in the case of an error that has no actual financial harm to the MEMBER or PLAN. An error that is the result of PHARMACY failing to comply with a formal corrective action plan may be subject to recoupment; and

h) Not allow interest to accrue during the audit period for either party, beginning with the notice of the audit and ending with the final audit report.

4. Validation

   a) To validate a pharmacy record and the delivery of a pharmacy service, PHARMACY may use an authentic and verifiable statement or record, including a medication administration record of a nursing home, assisted-living facility, hospital, physician, or other authorized practitioner or an additional audit documentation parameter located in the provider manual.

   b) Any legal prescription that meets the requirements in this section may be used to validate a claim in connection with a prescription, refill, or change in a prescription, including a medication administration record, fax, e-prescription, or documented telephone call from the prescriber to the prescriber's agent.

5. The AUDITING ENTITY conducting the audit shall follow the written appeal process detailed herein, PBM's policies & procedures, or the provider manual, as applicable, which includes procedures for appealing both a preliminary audit report and a final audit report.

6. A preliminary audit report shall be delivered to PHARMACY within one hundred twenty days after the conclusion of the audit.

   a) PHARMACY shall be allowed at least thirty days following receipt of a preliminary audit report to provide documentation to address any discrepancy found in the audit.

   b) A final audit report shall be delivered to PHARMACY within one hundred twenty days after receipt of the preliminary audit report or the appeal process has been exhausted, whichever is later.

   c) AUDITING ENTITY shall remit any money due to PHARMACY as the result of an underpayment of a claim within forty-five days after the appeal process has been exhausted and the final audit report has been issued.

7. Where contractually required, AUDITING ENTITY shall provide a copy to the PLAN SPONSOR of any of the PLAN SPONSOR's claims that were included in the audit, and any recouped money shall be returned to the PLAN or PLAN SPONSOR.

8. This section IV does not apply to any investigative audit that involves suspected fraud, willful misrepresentation, or abuse, or any audit completed by a state-funded health care program.

9. 340B
   a) The Parties understand that a 340B contract pharmacy will be paid at the same rate for the same drug as similarly situated pharmacies that are not 340B entities or 340B contracted pharmacies.

b) Capital Rx shall not assess any fee, chargeback, or other adjustment upon the 340B entity or 340B contract pharmacy on the basis that the 340B entity or 340B contract pharmacy participates in the program.
c) Capital Rx shall not discriminate against a 340B entity or 340B contract pharmacy in a manner that prevents or interferes with a covered individual's choice to receive such drug from the corresponding 340B entity or 340B contract pharmacy.

New Mexico State Exhibit

The following State Exhibit sets forth certain state regulatory requirements that will apply only in the state of New Mexico.

1) **Audits.** To the extent required by N.M. Stat. Ann. § 61-11-18.2(8), an audit of the records of a Pharmacy by Capital Rx or its auditors shall not exceed two years from the date the claim was submitted to or adjudicated by Capital Rx, unless it conflicts with state or federal law. Capital Rx shall not reduce or eliminate payment on an adjudicated claim except as permitted by Section 61-11-18.2 NMSA 1978.

2) **Pricing and Appeals.** Pharmacies will receive notification of the appropriate reimbursement amount and payment per such reimbursement amount. Such reimbursement will be based upon the applicable NADAC or AWP price pursuant to the reimbursement terms of the pharmacy's contract with Capital Rx. In the event a pharmacy or its PSAO wishes to submit a pricing appeal, such appeal must be submitted within twenty-one (21) business days following receipt of the payment of the claim which is the basis of the appeal. The appeal may be submitted to Capital Rx at pricing.appeals@cap-rx.com. Questions related to pricing appeals can be directed to pricing.appeals@cap-rx.com or 833-502-1220. Additional information can be found on the Capital Rx website. Capital Rx will review the information submitted in the appeal and will provide a response within fourteen (14) business days after all the information is submitted to Capital Rx.

   Within one (1) business day of determination, Capital Rx will notify the appealing pharmacy and other applicable pharmacies of its decision to approve or deny the appeal.

   If the appeal is resolved in the pharmacy's favor, Capital Rx will update the pricing appropriately on the day of resolution for the appeal pharmacy and all applicable similarly situated network pharmacies in New Mexico. Such pharmacies will be allowed to reverse and resubmit applicable Claims to capture the updated pricing. Similarly situated pharmacy shall to a network pharmacy whose contract with Capital Rx is subject to the same reimbursement for the Claim as a pharmacy whose appeal was granted.

   If the appeal is resolved against the pharmacy, Capital Rx will provide the challenging pharmacy and its pharmacy services administrative organization, if any, the national drug code number and supplier that has the product available for purchase in New Mexico at or below the cost for the basis of the appeal.

   In the event Capital Rx fails to respond to a pharmacy's complete pricing appeal submission in writing within fourteen (14) business days after it receives the appeal, such appeal will be resolved in the appeal pharmacy's favor.

   Pharmacies are required to submit the applicable information below for the particular drug/NDC subject to the appeal in order for their appeal to be reviewed.

a) fill date;
b) BIN number (six digits);
c) NCPDP (seven digits);
d) Rx number;
e) NDC 11 (11 digits);
f) drug name;
g) drug strength;
h) invoice price and net purchase price of drug (whole dollar with two decimal places);
i) total reimbursement (whole dollar with two decimal places);
j) reason for review;
a) any information required by contract; and
b) notes (optional).

Pharmacies may access the NADAC pricing at: https://data.medicaid.gov/nadac.

3) **Additional Terms**.
   a) Pharmacies shall be allowed to:
      i) mail or deliver drugs to a patient as an ancillary service;
      ii) provide a patient with information regarding their total cost for pharmacist services for a prescription drug; or
      iii) discuss information regarding the total cost for pharmacist services for a prescription drug
      iv) sell a more affordable alternative to the insured if a more affordable alternative is available;
      v) source or procure generic drugs at their option;
      vi) disclose information by a pharmacist or pharmacy to the New Mexico superintendent; or
      vii) provide to the state or federal government officials with general information for public policy purposes.

   b) 340B
      i) The Parties understand that a 340B contract pharmacy will be paid at the same rate for the same drug as similarly situated pharmacies that are not 340B entities or 340B contracted pharmacies.
      ii) Capital Rx shall not assess any fee, chargeback, or other adjustment upon the 340B entity or 340B contract pharmacy on the basis that the 340B entity or 340B contract pharmacy participates in the program.
      iii) Capital Rx shall not discriminate against a 340B entity or 340B contract pharmacy in a manner that prevents or interferes with a covered individual's choice to receive such drug from the corresponding 340B entity or 340B contract pharmacy.
   c) Prescription Synchronization
      In accordance with applicable New Mexico state law and as allowed per the Member's pharmacy benefit, Capital Rx shall allow a pharmacy to override any denial indicating that a prescription is being refilled too soon for the purposes of medication synchronization, and shall not prorate a dispensing fee to a pharmacy that fills a prescription with less than a thirty-day supply of prescription drug pursuant to allowed prescription synchronization services.

New York State Exhibit

The following State Exhibit sets forth certain state regulatory requirements that will apply only in the state of New York.

1) **Definitions for Purposes of this Exhibit**

a) “Managed Care Organization" or "MCO" shall mean the person, natural or corporate, or any groups of such persons, certified under Public Health Law Article 44, who enter into an arrangement, agreement or plan or any combination of arrangements or plans which provide or offer, or which do provide or offer, a comprehensive health services plan.
b) "Independent Practice Association" or "IPA" shall mean an entity formed for the limited purpose of arranging by contract for the delivery or provision of health services by individuals, entities and facilities licensed or certified to practice medicine and other health professions, and, as appropriate, ancillary medical services and equipment, by which arrangements such health care providers and suppliers will provide their services in accordance with and for such compensation as may be established by a contract between such entity and one or more MCOs.
c) "IPA" may also include, for purposes of this Agreement, a pharmacy or laboratory with the legal authority to contract with other pharmacies or laboratories to arrange for or provide services to enrollees of a New York State MCO.
d) "Provider" shall mean physicians, dentists, nurses, pharmacists and other health care professionals, pharmacies, hospitals and other entities engaged in the delivery of health care services which are licensed, registered and/or certified as required by applicable federal and state law.

2) **General Terms and Conditions**
a) This Agreement is subject to the approval of the New York State Department of Health and if implemented prior to such approval, the Parties agree to incorporate into this Agreement any and all modifications required by the Department of Health (“DOH”) for approval or, alternatively, to terminate this Agreement if so directed by the Department of Health, effective sixty (60) calendar days subsequent to notice, subject to Public Health Law §4403(6) (e). This Agreement is the sole agreement between the Parties regarding the arrangement established herein.
b) Any material amendment to this Agreement is subject to the prior approval of the Department of Health, and any such amendment shall be submitted for approval at least thirty (30) calendar days, or ninety (90) calendar days if the amendment adds or materially changes a risk sharing arrangement that is subject to Department of Health review, in advance of anticipated execution. To the extent the MCO provides and arranges for the provision of comprehensive health care services to enrollees served by the Medical Assistance Program, the MCO shall notify and/or submit a copy of such material amendment to DOH or New York City, as may be required by the Medicaid managed care contract between the MCO and DOH (or New York City) and/or the Family Health Plus contract between the MCO and DOH.
c) Assignment of an agreement between an MCO and (1) an IPA, (2) institutional network Provider, or (3) medical group Provider that serves five percent or more of the enrolled population in a county, or the assignment of an agreement between an IPA and (1) an institutional Provider or (2) medical group Provider that serves five percent or more of the enrolled population in a county, requires the prior approval of the Commissioner of Health.
d) The Provider agrees, or if the Agreement is between the MCO and an IPA or between an IPA and an IPA, the IPA agrees and shall require the IPA's providers to agree, to comply fully and abide by the rules, policies and procedures that the MCO (a) has established or will establish to meet general or specific obligations placed on the MCO by statute, regulation, or DOH or SID guidelines or policies and (b) has provided to the Provider at least thirty (30) calendar days in advance of implementation, including but not limited to:
    i) quality improvement/management;
    ii) utilization management, including but not limited to precertification procedures, referral process or protocols, and reporting of clinical encounter data;
    iii) member grievances; and
    iv) provider credentialing.
e) The Provider or, if the Agreement is between the MCO and an IPA, or between an IPA and an IPA, the IPA agrees, and shall require its Providers to agree, to not discriminate against an enrollee

based on color, race, creed, age, gender, sexual orientation, disability, place of origin, source of payment or type of illness or condition.

f) If the Provider is a primary care practitioner, the Provider agrees to provide for twenty-four (24) hour coverage and back up coverage when the Provider is unavailable. The Provider may use a twenty-four (24) hour back-up call service provided appropriate personnel receive and respond to calls in a manner consistent with the scope of their practice.

g) The MCO or IPA which is a party to this Agreement agrees that nothing within this Agreement is intended to, or shall be deemed to, transfer liability for the MCO's or IPA's own acts or omissions, by indemnification or otherwise, to a Provider.

h) Notwithstanding any other provision of this Agreement, the parties shall comply with the provisions of the Managed Care Reform Act of 1996 (Chapter 705 of the Laws of 1996) Chapter 551 of the Laws of 2006, Chapter 451 of the Laws of 2007, Chapter 237 of the Laws of 2009, Chapter 297 of the Laws of 2012, Chapter 199 of the Laws of 2014, Part H, Chapter 60, of the Laws of 2014 and Chapter 6 of the Laws of 2015 with all amendments thereto.

i) To the extent the MCO enrolls individuals covered by the Medical Assistance Programs, this Agreement incorporates the pertinent MCO obligations under the Medicaid managed care contract between the MCO and DOH (or New York City) and/or the Family Health Plus contract between the MCO and DOH as if set forth fully herein, including:

   i) The MCO will monitor the performance of the Provider or IPA under the Agreement, and will terminate the Agreement and/or impose other sanctions, if the Provider's or IPA's performance does not satisfy standards set forth in the Medicaid managed care contracts.

   ii) The Provider or IPA/ACO agrees that the work it performs under the Agreement will conform to the terms of the Medicaid managed care contract between the MCO and DOH and that it will take corrective action if the MCO identifies deficiencies or areas of needed improvement in the Provider's or IPA/ACO's performance.

   iii) The Provider or IPA agrees to be bound by the confidentiality requirements set forth in the Medicaid managed care contract between the MCO and DOH.

   iv) The MCO and the Provider or IPA agree that a woman's enrollment in the MCO's Medicaid managed care product is sufficient to provide services to her newborn, unless the newborn is excluded from enrollment in Medicaid managed care or the MCO does not offer a Medicaid managed care product in the mother's county of fiscal responsibility.

   v) The MCO shall not impose obligations and duties on the Provider or IPA that are inconsistent with the Medicaid managed care contracts, or that impair any rights accorded to DOH, the local Department of Social Services, or the United States Department of Health and Human Services.

   vi) The Provider or IPA agrees to provide medical records to the MCO for purposes of determining newborn eligibility for Supplemental Security Income where the mother is a member of the MCO and for quality purposes at no cost to the MCO.

   vii) The Provider or IPA agrees, pursuant to 31 U.S.C. § 1352 and CFR Part 93, that no federally appropriated funds have been paid or will be paid to any person by or on behalf of the MCO 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 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.

   viii) 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 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 of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or

cooperative agreement, and the Agreement exceeds $100,000 the Provider or IPA shall complete and submit Standard Form LLL "Disclosure Form to Report Lobbying," in accordance with its instructions.

ix) The Provider agrees to disclose to MCO on an ongoing basis, any managing employee that has been convicted of a misdemeanor or felony related to the person's involvement in any program under Medicare, Medicaid or a Title XX services program (block grant programs).

x) The Provider agrees to monitor its employees and staff against the List of Excluded Individuals and Entities (LEIE) and excluded individuals, the Social Security Administration Death Master List, and the National Plan Provider Enumeration System (NPPES).

xi) The Provider agrees to disclose to MCO complete ownership, control, and relationship information.

xii) Provider agrees to obtain for MCO ownership information from any subcontractor with whom the provider has had a business transaction totaling more than $25,000, during the 12-month period ending on the date of the request made by SDOH, OMIG or DHHS. The information requested shall be provided to MCO within 35 days of such request.

j) Provider understands it is subject to the statutes, rules, regulations, and applicable Medicaid Updates of the Medicaid program and of DOH related to the furnishing of care, services or supplies provided directly by, or under the supervision of, or ordered, referred or prescribed by the subcontractor. This includes 18 NYCRR 515.2 except to the extent that any reference in the regulation establishing rates, fees, and claiming instructions will refer to the rates, fees and claiming instructions set by the MCO.

k) The parties to this Agreement agree to comply with all applicable requirements of the Federal Americans with Disabilities Act.

l) Provider agrees to comply with all applicable requirements of the Health Insurance Portability and Accountability Act, the HIV confidentiality requirements of Article 27-F of the Public Health Law, and Mental Hygiene Law § 33.13.

m) Compliance Program. Provider agrees that if it claims, orders, or is paid $500,000 or more per year from the Medical Assistance Program, including, in the aggregate, claims submitted to or paid directly by the Medical Assistance Program and/or claims submitted to or paid by any MCO under the Medicaid Managed Care Program, that it shall adopt and implement a compliance program which meets the requirements of New York State Social Services Law § 363-d(2) and 18 NYCRR § 521.3.

n) Compliance Program Certification. Provider agrees that if it is subject to the requirements of Section B (12) of this Appendix, it shall certify to DOH, using a form provided by OMIG on its website, within 30 days of entering into a Provider Agreement with the MCO, if they have not so certified within the past year that a compliance program meeting the requirements of 18 NYCRR §521.3 and Social Services Law § 363-d(2) is in place. The Provider shall recertify during the month of December each year thereafter using a form provided by OMIG on OMIG's website.

o) The Provider agrees to comply with all applicable requirements of the Health Insurance Portability and Accountability Act; the HIV confidentiality requirements of Article 27F of the Public Health Law and Mental Hygiene Law § 33.13.

3) Payment/Risk Arrangements

a) **Enrollee Non-liability**. Provider agrees that in no event, including, but not limited to, nonpayment by the MCO or IPA, insolvency of the MCO or IPA, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a subscriber, an enrollee or person (other than the MCO or IPA) acting on his/her/their behalf, for services provided pursuant to the subscriber contract or Medicaid managed care contract or Family Health Plus contract and this Agreement, for the period covered by the paid enrollee premium. In addition, in the case of Medicaid managed care, Provider agrees that, during the time an enrollee is enrolled in the MCO, he/she/it will not bill the New York State Department of Health or the City of New York for Covered Prescription Services within the

Medicaid managed care benefit package as set forth in the Agreement between the MCO and the New York State Department of Health. In the case of Family Health Plus, Provider agrees that, during the time an enrollee is enrolled in the MCO, he/she/it will not bill the New York State Department of Health for Covered Prescription Services within the Family Health Plus benefit package, as set forth in the Agreement between the MCO and the New York State Department of Health. This provision shall not prohibit the provider, unless the MCO is a managed long term care plan designated as a Program of All-Inclusive Care for the Elderly (PACE), from collecting copayments, coinsurance amounts, or permitted deductibles, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to a covered person provided that Provider shall have advised the enrollee in writing that the service is uncovered and of the enrollee's liability therefore prior to providing the service. Where the Provider has not been given a list of services covered by the MCO, and/or Provider is uncertain as to whether a service is covered, the Provider shall make reasonable efforts to contact the MCO and obtain a coverage determination prior to advising an enrollee as to coverage and liability for payment and prior to providing the service. This provision shall survive termination of this Agreement for any reason, and shall supersede any oral or written agreement now existing or hereafter entered into between Provider and enrollee or person acting on his or her behalf.

b) **Coordination of Benefits (COB).** To the extent otherwise permitted in this Agreement, the Provider may participate in collection of COB on behalf of the MCO, with COB collectibles accruing to the MCO or to the provider. However, with respect to enrollees eligible for medical assistance, or participating in Child Health Plus or Family Health Plus, the Provider shall maintain and make available to the MCO records reflecting COB proceeds collected by the Provider or paid directly to enrollees by third party payers, and amounts thereof, and the MCO shall maintain or have immediate access to records concerning collection of COB proceeds.

c) If the Provider is a health care professional licensed, registered or certified under Title 8 of the Education Law, the MCO or the IPA must provide notice to the Provider at least ninety (90) calendar days prior to the effective date of any adverse reimbursement arrangement as required by Public Health Law § 4406-c (5- c). Adverse reimbursement change shall mean a proposed change that could reasonably be expected to have a negative impact on the aggregate level of payment to Provider. This provision does not apply if the reimbursement change is required by law, regulation or applicable regulatory authority; is required as a result of changes in fee schedules, reimbursement methodology or payment policies established by the American Medical Association current procedural terminology (CPT) codes, reporting guidelines and conventions; or such change is expressly provided for under the terms of this Agreement by the inclusion or reference to a specific fee or fee schedule, reimbursement methodology or payment policy indexing scheme.

d) The Parties agree to comply with and incorporate the requirements of Physician Incentive Plan (PIP) Regulations contained in 42 CFR §438.6(h), 42 CFR § 422.208, and 42 CFR § 422.210 into any contracts between the contracting entity (Provider, IPA, hospital, etc.) and other persons/entities for the provision of services under this Agreement. No specific payment will be made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an enrollee.

e) The Parties agree that a claim for home health care services following an inpatient hospital stay cannot be denied on the basis of medical necessity or a lack of prior authorization while a utilization review determination is pending if all necessary information was provided before a member's inpatient hospital discharge, consistent with Public Health Law § 4903.

f) The parties agree that, where required by Public Health Law §4903, a claim for certain continued, extended, or additional health care services cannot be denied on the basis of medical necessity or a lack of prior authorization while a utilization review determination is pending if all necessary information was provided within the required timeframes and under the circumstances described in Public Health Law §4903.

g) The parties agree to follow Section 3224-a of the Insurance Law providing timeframes for the submission and payment of Provider claims to the MCO.

h) The parties agree to follow Section 3224-b(b) of the Insurance Law prohibiting an MCO from initiating overpayment recovery efforts more than 24 months after the original payment was received by a health care Provider, except where: (1) the plan makes overpayment recovery efforts that are based on a reasonable belief of fraud or other intentional misconduct or abusive billing; (2) for the Medicaid Managed Care and Family Health Plus programs, the overpayment recovery period for such programs is six years from date payment was received by the health care Provider with written notice 30 days prior to engaging in overpayment recovery efforts. Such notice must state the patient's name, service date, payment amount, proposed adjustment, and a reasonably specific explanation of the proposed adjustment.

i) The parties agree to follow Section 3224-c of the Insurance Law providing that claims cannot be denied solely on the basis that the MCO has not received from the member information concerning other insurance coverage.

j) The parties agree that this contract does not waive, limit, disclaim, or in any way diminish the rights that any Provider may have pursuant to Section 3238 of the Insurance Law to the receipt of claims payment for services where preauthorization was required and received from the appropriate person or entity prior to the rendering of the service.

k) If applicable, the parties agree that for a contract involving Tier 2 or 3 arrangements as described in Section VII.B of the Guidelines, the contract must:
   i) Provide for the MCO's ongoing monitoring of Provider financial capacity and/or periodic Provider financial reporting to the MCO to support the transfer of risk to the Provider; and
   ii) Include a provision to address circumstance where the Provider's financial condition indicates an inability to continue accepting such risk; and
   iii) Address MCO monitoring of the financial security deposit, describing the method and frequency of monitoring and recourse for correcting underfunding of the deposit to be maintained by the MCO; and
   iv) Include a provision that the Provider will submit any additional documents or information related to its financial condition to the MCO, if requested by DOH.

l) If applicable, the parties agree that for any contract involving an MCO and IPA/ACO, the contract must include provisions whereby:
   i) The parties expressly agree to amend or terminate the contract at the direction of DOH (applies to Tier 1, Tier 2, and Tier 3);
   ii) The IPA/ACO will submit annual financial statements to the MCO, as well as any additional documents required by the MCO as necessary to assess the IPA/ACO's progress towards achieving value-based payment goals as specified in the Roadmap, and the MCO will notify DOH of any substantial change in the financial condition of the IPA/ACO (applies to Tier 2 and Tier 3); and
   iii) The IPA/ACO will submit any additional documents or information related to its financial condition to the MCO, if requested by DOH (applies to Tier 2 and Tier 3); and
   iv) The parties agree that all Provider contracts will contain provision prohibiting Providers, in the event of a default by the IPA/ACO, from demanding payment from the MCO for any covered services rendered to the MCO's enrollees for which payment was made by the MCO to the IPA/ACO pursuant to the risk agreement (applies to Tier 2 and Tier 3).

4) Records Access

a) Pursuant to appropriate consent/authorization by the enrollee, the Provider will make the enrollee's medical records and other personally identifiable information (including encounter data for government-sponsored programs) available to the MCO (and IPA if applicable), for purposes including preauthorization, concurrent review, quality assurance, and Provider claims processing, payment, member qualification for other government programs including, but not limited to, newborn eligibility for Supplemental Security Income, and for MCO/Manager analysis

and recovery of overpayments due to fraud and abuse. The Provider will also make enrollee medical records available to the State for management audits, financial audits, program monitoring and evaluation, licensure or certification of facilities or individuals, and as otherwise required by state law. The Provider shall provide copies of such records to DOH at no cost. The Provider (or IPA if applicable) expressly acknowledges that he/she/it shall also provide to the MCO and the State (at no expense to the State), on request, all financial data and reports, and information concerning the appropriateness and quality of services provided, as required by law. These provisions shall survive termination of the contract for any reason.

b) When such records pertain to Medicaid or Family Health Plus reimbursable services the Provider agrees to disclose the nature and extent of services provided and to furnish records to DOH and/or the United States Department of Health and Human Services, the County Department of Social Services, the Comptroller of the State of New York, the Office of the Medicaid Inspector General, the New York State Attorney General, and the Comptroller General of the United States and their authorized representatives upon request. This provision shall survive the termination of this Agreement regardless of the reason.

c) The parties agree that medical records shall be retained for a period of six (6) years after the date of service, and in the case of a minor, for three (3) years after majority or six (6) years after the date of service, whichever is later, or for such longer period as specified elsewhere within this Agreement. This provision shall survive the termination of this Agreement regardless of the reason.

d) The MCO and the Provider agree that the MCO will obtain consent directly from enrollees at the time of enrollment or at the earliest opportunity, or that the Provider will obtain consent from enrollees at the time service is rendered or at the earliest opportunity, for disclosure of medical records to the MCO, to an IPA or to third parties. If the Agreement is between an MCO and an IPA, or between an IPA and an IPA, the IPA agrees to require the Providers with which it contracts to agree as provided above. If the Agreement is between an IPA and a Provider, the Provider agrees to obtain consent from the enrollee if the enrollee has not previously signed consent for disclosure of medical records.

5) Termination and Transition

a) Termination or non-renewal of an agreement between an MCO and an IPA, institutional network Provider, or medical group Provider that serves five percent or more of the enrolled population in a county, or the termination or non-renewal of an agreement between an IPA and an institutional Provider or medical group Provider that serves five percent or more of the enrolled population in a county, requires notice to the Commissioner of Health. Unless otherwise provided by statute or regulation, the effective date of termination shall not be less than forty-five (45) calendar days after receipt of notice by either Party, provided, however, that termination, by the MCO may be effected on less than forty-five (45) calendar days' notice provided the MCO demonstrates to DOH's satisfaction prior to termination that circumstances exist which threaten imminent harm to enrollees or which result in Provider being legally unable to deliver the covered services and, therefore, justify or require immediate termination.

b) If this Agreement is between the MCO and a health care professional, the MCO shall provide to such health care professional a written explanation of the reasons for the proposed contract termination, other than non-renewal, and an opportunity for a review as required by state law. The MCO shall provide the health care professional sixty (60) calendar days' notice of its decision to not renew this Agreement.

c) If this Agreement is between an MCO and an IPA, and the Agreement does not provide for automatic assignment of the IPA's Provider contracts to the MCO upon termination of the MCO/IPA contract, in the event either Party gives notice of termination of the Agreement, the Parties agree, and the IPA's Providers agree, that the IPA Providers shall continue to provide care to the MCO's enrollees pursuant to the terms of this Agreement for one hundred eighty (180) calendar days following the effective date of termination, or until such time as the MCO makes

other arrangements, whichever first occurs. This provision shall survive termination of this Agreement regardless of the reason for the termination.

d) **Continuation of Treatment.** The Provider agrees that in the event of MCO or IPA insolvency or termination of this contract for any reason, the Provider shall continue, until medically appropriate discharge or transfer, or completion of a course of treatment, whichever occurs first, to provide services pursuant to the subscriber contract, Medicaid managed care contract, or Family Health Plus contract, to an enrollee confined in an inpatient facility, provided the confinement or course of treatment was commenced during the paid premium period. For purposes of this clause, the term "Provider" shall include the IPA and the IPA's contracted Providers if this Agreement is between the MCO and an IPA. This provision shall survive termination of this Agreement.

e) Notwithstanding any other provision herein, to the extent that the Provider is providing health care services to enrollees under the Medicaid Program and/or Family Health Plus, the MCO or IPA retains the option to immediately terminate the Agreement when the Provider has been terminated or suspended from the Medicaid Program.

f) In the event of termination of this Agreement, the Provider agrees, and, where applicable, the IPA agrees to require all participating providers of its network to assist in the orderly transfer of enrollees to another provider.

6) Arbitration

a) To the extent that arbitration or alternative dispute resolution is authorized elsewhere in this Agreement, the Parties to this Agreement acknowledge that the Commissioner of Health is not bound by arbitration or mediation decisions. Arbitration or mediation shall occur within New York State, and the Commissioner of Health will be given notice of all issues going to arbitration or mediation, and copies of all decisions.

7) IPA-Specific Provisions

a) Any reference to IPA quality assurance (QA) activities within this Agreement is limited to the IPA's analysis of utilization patterns and quality of care on its own behalf and as a service to its contract Providers.

8) New York State Medicaid Additional Terms

a) **Cultural Competency Training:** Pharmacy is required to certify, on an annual basis, completion of State-approved cultural competence training curriculum, including training on the use of interpreters, for all Participating Providers' staff who have regular and substantial contact with Enrollees." Certification of such training should be kept on file and made available to Capital Rx, to be provided upon request to DOH.

North Carolina State Exhibit

The following State Exhibit sets forth certain state regulatory requirements that will apply only in the state of North Carolina.

1) **Claims Submission and Prompt Payment.** In order to receive payment, each PHARMACY must submit a Clean Claim to Claims Processor for each Covered Prescription Service dispensed via the POS System. PHARMACY is responsible for the payment of any and all transaction charges or fees associated with the transmission of claims or claim information to PBM. A Clean Claim must be submitted to Claims Processor within one hundred eighty (180) days after the date of service. If any Claim is rejected or if additional information is required for further processing by PBM or its Claims Processor, PHARMACY must resubmit the Claim within sixty (60) days of PHARMACY's receipt of such rejected Claim provided that the resubmitted Claim may only be processed and paid if it is a Clean Claim and subject to receipt of payment from the applicable Client. Unless otherwise agreed to by the PBM or Client, Claims submitted after the time periods set forth in this Section will not be eligible for payment. PBM will

promptly pay Clean Claims in accordance with the Agreement and North Carolina General Statute 58-3-225.

2) **PHARMACY Administrative Duties and Records.** Pharmacy shall assure that administrative duties will be transitioned and that records will also be transitioned and readily available upon termination of the Agreement or insolvency, pursuant to Title 11 of the North Carolina Administrative Code Section 20.0202(5).

3) **Credentialing Verification and Sanction Program Compliance.** PHARMACY shall comply with PBM's and Client's credential verification and sanctions program, as applicable and pursuant to Title 11 of the North Carolina Administrative Code Section 20.0202(16). In addition, PHARMACY shall maintain licensure, accreditation and credentials sufficient to meet PBM's credential verification program requirements and to notify PBM of subsequent changes in status of any information relating to PHARMACY's professional credentials, as applicable and pursuant to Title 11 of the North Carolina Administrative Code Section 20.0202(6).

4) **PHARMACY Professional Liability Insurance.** PHARMACY shall maintain professional liability insurance coverage in an amount acceptable to PBM and notify the PBM of subsequent changes in status of professional liability insurance Title 11 of the North Carolina Administrative Code Section 20.0202(7).

5) **PHARMACY Professional and Ethical Responsibility.** Notwithstanding the requirements of PHARMACY to comply with PBM's and Client's applicable credential verification, sanctions, utilization management and quality management programs, such compliance shall not override the professional or ethical responsibility of PHARMACY or interfere with the PHARMACY's ability to provide information or assistance to customers.

6) **Assignment.** PHARMACY's duties and obligations under the Agreement shall not be assigned, delegated or transferred without the prior written consent of PBM. PHARMACY will notify the PBM, in writing, of any duties or obligations that are to be delegated or transferred before the delegation or transfer.

7) **Member Eligibility Verification.** PBM shall provide via the POS System the ability to verify Member eligibility, based on PBM's current information prior to rendering Covered Prescription Services.

8) **Data and Information to PHARMACY.** PBM will make available to PHARMACY information on performance feedback reports or information to the provider, if compensation is related to efficiency criteria, benefit exclusions; administrative and utilization management requirements; and credential verification, quality assessment and provider sanction programs, as applicable. Notification of changes in such requirements will be provided by PBM in a manner to allow PHARMACY to timely comply with such changes.

9) **Member Records.** PHARMACY shall maintain the confidentiality of Member's medical records, personal information and other health records as required by law, pursuant to Title 11 of the North Carolina Administrative Code Section 20.0202(11)(a).

10) **Member Billing.** To the extent applicable, when Covered Prescription Services are delivered on a prepaid basis under G.S. 58, Article 67, PHARMACY shall not bill any Member for Covered Prescription Services, except for specified Cost Sharing Amounts. However, PHARMACY and Member may agree to continue non-Covered Prescription Services at the Member's own expense, as long as the

PHARMACY has notified the Member in advance that the PBM may not cover or continue to cover specific services and the Member chooses to receive the service. PHARMACY will not collect Cost Sharing Amounts for non-Covered Prescription Services.

11) **Prompt Claim Payments.**

a) As applicable, PBM shall pay claims and provide PHARMACY notices in accordance with Title 11 NCGS Section 58-3-225, including PBM shall within 30 calendar days after receipt of a claim, send by electronic or paper mail to the claimant: (1) Payment of the claim; (2) Notice of denial of the claim; (3) Notice that the proof of loss is inadequate or incomplete; (4) Notice that the claim is not submitted on the form required by the Benefit Plan, by the Agreement or by applicable law; (5) Notice that coordination of benefits information is needed in order to pay the claim; and (6) Notice that the claim is pending based on nonpayment of fees or premiums.

b) If PBM requests additional information from PHARMACY, including the information in subsection 10(A) above, and PBM does not receive such information within ninety (90) days of such request, PBM shall deny the claim and send the notice of denial to the claimant in accordance with subsection (c) of Title 11 NCGS Section 58-3-225. However, and as noted in the notice to claimant, PBM will reopen claim if the requested information is submitted to PBM within one (1) year after the date of the denial notice closing the claim.

c) Benefit Plan claim payments that are not made in accordance with Title 11 NCGS Section 58-3-225(c) shall bear interest at the annual percentage rate of eighteen percent (18%) beginning on the date following the day on which the claim should have been paid. However, such interest does not apply to claims for non-Covered Prescription Services nor to Cost Sharing Amounts.

d) PHARMACY shall submit claims within 180 days after the date of the provision of Covered Prescription Services to Member, except as allowed by Title 11 NCGS Section 58-3-225(f).

e) If a claim for which the claimant is a PHARMACY has not been paid or denied within sixty (60) days after receipt of the initial claim, PBM shall send a claim status report to Member. However, the claims status report is not required during the time PBM is awaiting information requested under subsection (B) of this Section 10. The report shall indicate that the claim is under review and PBM is communicating with PHARMACY to resolve the matter. While a claim remains unresolved, PBM shall send a claim status report to the Member with a copy to PHARMACY thirty (30) days after the previous report was sent.

f) PBM may recover overpayments made to PHARMACY by making demands for refunds and by offsetting future payments in accordance with Title 11 NCGS Section 58-3-225(h), including providing at least a thirty (30) calendar days prior written notice to the PHARMACY before offsetting future payments or recovering overpayments.

g) PHARMACY shall maintain written or electronic records of its activities under and in accordance with Title 11 NCGS Section 58-3-225, including, records of when each claim was received, paid, denied, or pended, and PBM's review and handling of each claim.

12) **Amendments.** Any proposed amendments to the Agreement shall be in accordance with NCGS 58-50-271 to the PHARMACY Notice contact noted in the Agreement and shall be dated, labeled "Amendment", signed by PBM and include an effective date for the proposed amendment.

13) **Policies and Procedures.** PBM shall provide a copy of its applicable policies and procedures, including the PBM Benefit Manual to PHARMACY prior to execution of a new or amended agreement and annually to all participating pharmacies.

14) **North Carolina Governing Law.** The governing law for purposes of this Agreement with PHARMACY shall be the laws of North Carolina.

Appendix B

Medicare Part D

A. Excluded Drugs

a. Specific drug products or drug categories may be excluded from Part D coverage due to federal regulations such as the Social Security Act under Section 1927 (d)(2). These drugs are prohibited from coverage and are not appealable through a coverage determination process. Some examples, including but not limited to, are listed below:

i. Prescription vitamins and mineral products, with the exception of formulary prenatal vitamins and fluoride preparations.
ii. Agents when used for anorexia, weight loss, or weight gain; even if used for non-cosmetic purpose (i.e. morbid obesity).
iii. Agents when used to promote fertility
iv. Agents when used for cosmetic purposes or hair growth
v. Agents when used for the symptomatic relief of cough and colds
vi. Nonprescription or over-the-counter (OTC) drugs (with the exception of Insulin and associated medical supplies
vii. Drug Efficacy Study Implementation (DESI) drug products that are considered "Less-Than-Effective"
viii. Agents when used for the treatment of sexual or erectile dysfunction
ix. Covered outpatient Drug Products for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale
x. End-Stage Renal Disease (ESRD) agents furnished to ESRD patients on dialysis
xi. Agents without New Drug Application (NDA) or Abbreviated New Drug Application (ANDA) with the FDA.
xii. Any brand agent for which the manufacturer has not agreed to participate in the gap discount program (i.e. labeler code agreement).
xiii. Drug Products related to terminal illness furnished to Hospice patients
xiv. Compounded Drugs that contain at least one ingredient covered under Medicare Part B.
xv. Bulk ingredients/powders used in Compounded Drugs.
xvi. Self-administered oral anti-cancer agents with the same active ingredients and indications as chemotherapy agents administered as incident to a Prescriber's professional service.

B. Medicare Part A/B/D Coordination of Benefits (COB)

a. Coordination of benefit is a process to determine order of payment of claims when multiple payers for the same service exist. This process ensures that the primary payer adjudicates the initial claim and prevents duplication of payment between other secondary payer(s). CMS requires Medicare Plan Sponsors to perform coordination of benefits to ensure accurate payments between Medicare benefits such as Part A and Part B. For Part D, this provides a method to track and to calculate a member's true out-of-pocket (TrOOP) expenditures, which is a key information to administer Medicare coverage phases.

b. Pharmacies will receive claim messages indicating if other payer or other Medicare benefit exists. Pharmacies would have to bill to the primary payer or have to bill to the correct Medicare benefit. At times, a coverage determination may be needed to determine the indicated use so the correct Medicare benefit covers the product.

C. **Medicare Part D Clean Claim Determination**

a. All claims submitted by Pharmacies for Medicare Part D Drugs are submitted by applicable Medicare Part D Plan Sponsors to CMS as Prescription Drug Events (PDE). If CMS rejects or retro-actively denies a PDE because the PDE is not consistent with CMS instructions, guidance, regulations or applicable law, the underlying Claim may be deemed not a Clean Claim and may be tagged for correction by PBM on behalf of the Medicare Part D Sponsor to ensure the Member's TrOOP is correct. If a Medicare Part D Sponsor's PDE is not accepted by CMS due to any fault by Pharmacy, PBM reserves the right to recoup applicable amounts for the unaccepted PDE on behalf od the Medicare Part D Plan Sponsor.

D. **Medicare Part D Coverage Determination**

a. Coverage determination is a Medicare process of reviewing exception requests to determine coverage of drug products under the Part D benefit. Through the process, Medicare Plan Sponsors determine if the drug product is being used for medically accepted indications, if the drug is being used safely, if the drug is appropriately dosed, if member has had appropriate medications trials, or if coverage is under the appropriate Medicare benefit. A member, member's appointed or authorized representative, or prescriber may initiate a coverage determination.

b. If the Medicare Plan Sponsor approves a coverage determination request, the member, the member's appointed or authorized representative, and the prescriber will be notified of the approval and the approval will remain in effect at least until the end of the year. Members can obtain the drug product as long as the prescriber determines that it is clinically appropriate, safe, and continues to prescribe it.

c. If the Medicare Plan Sponsor denies a coverage determination request, the member, the member's appointed or authorized representative, and the prescriber will be notified of the denial and their appeal rights. Instructions on how to appeal a decision will be outlined in the notification.

E. **Permissible prescriber identifiers for Medicare Part D claims**

a. For Medicare Part D and Medicaid Claims:

1) Pharmacy must submit a Prescriber NPI on all Part D and Medicaid Claim submissions. Claim submissions without a Prescriber ID will result in a Claim rejection with code 25 — Missing/Invalid Prescriber ID.
2) Organizational NPIs should not be submitted.
3) NPI should be submitted using an individual NPI that is valid on the Date of Service (DOS) for the Claim.
4) Claims submitted without a valid individual Prescriber NPI will reject with NCPDP Reject Code 619 — Prescriber Type 1 NPI Required, or 56 — "NPI EXISTS. PRESCRIBER ID INVALID/NOT ALLOWED" and the corresponding NPI number may be provided for use when resubmitting the Claim.
5) Prescribers with a current exclusion list sanction (i.e. Office of Inspector General's (OIG) — U.S. Department of Health & Human Services (HHS) ~ List of Excluded Individuals/Entities (LEIE), as well as General Services Administration (GSA) — System for Award Management (SAM) ~ Excluded Parties Listing System (EPLS)) will be rejected.
6) Prescriptions written for controlled substances: PBM will reject Claims where the Prescriber being submitted on the Claim does not have the authority to write for the schedule Drug Product being prescribed.

7) Note that it is critical that you enter the correct Prescriber DEA and NPI numbers because PBM sends correspondence to providers based on pharmacy Claims. If incorrect provider information is given, privacy incidents and Member safety issues may occur.

F. Coverage Determination Timeframes

a. **Standard Coverage Determination**
A coverage decision is provided within seventy-two (72) hours of receipt of the request or for an exceptions request, 72 hours after receipt of the Prescriber supporting statement. If the Medicare Part D Sponsor has not provided an answer within 72 hours after receiving a request or for an exceptions request, 72 hours after receipt of the Prescriber's supporting statement, the request will be automatically forwarded to an independent organization called an Independent Review Entity (IRE) for review.

b. **Expedited Coverage Determination**
A coverage decision is provided no later than twenty-four (24) hours of receipt of the request or for an exceptions request, 24 hours after receipt of the Prescriber's supporting statement. If the Medicare Part D Sponsor has not provided an answer within 24 hours after receiving a request or for an exceptions request, 24 hours after receipt of the Prescriber's supporting statement, the request will be automatically forwarded to an independent organization called an Independent Review Entity (IRE) for review.

G. Claim Submissions/Adjustments

Pharmacies are required to:

a. submit Part D Covered Prescription Services to Medicare Drug Plan Members via the POS System; and
b. furnish Part D Covered Prescription Drugs in a manner that permits the Part D Sponsor to comply with Medicare laws and regulations.
c. Note that failure to submit all Part D Covered Prescription Services may impact Part D Sponsor's STAR ratings as well as individual Medicare Drug Plan Member's benefit calculations.
d. Medicare Part D Claim adjustments:
    i. Note that Pharmacies will be unable to reverse Medicare Part D Claims that PBM has reprocessed internally. Pharmacies attempting to submit reversal requests on such Claims that have been reprocessed by PBM will receive a NCPDP Rejection stating — "CLAIM NOT ELIGIBLE FOR REVERSAL. CONTACT HELP DESK FOR ASSISTANCE".
    ii. If there is a need to resubmit Claims due to incorrect Medicare Part D Low Income Subsidy (LIS) level, please contact the phone number of the back of the Member's ID card.
    iii. In the Medicare Prescription Drug Benefit Manual, Chapter 14, CMS acknowledged the use of free or discounted drug programs and indicated claims must be submitted by pharmacies to allow for accurate reporting of Medicare Drug Plan and Member paid amounts. Please review the Submission of Pharmacy's Cash Price as the U&C Price within that Provider Manual for additional information, and ensure that claims for $0 prescription drug costs are submitted, unless the Member specifically requests that the claim not be processed using his/her prescription drug benefit.
    iv. To the extent permitted by CMS, Pharmacy agrees to not collect Member Cost-Sharing due to the presumption of Medicaid entitlement due to institutional status of the Member. Pharmacy certifies that as a condition for reimbursement

from PBM for claims in which the Medicare Part D Cost-Sharing has been reduced or waived:

1. Long Term care (LTC) is defined as patient residence codes 03-Nursing Facility/LTC and 09-Intermediate Care facility/Mentally Disabled ONLY.
2. Pharmacy has not and will not collect Cost-Sharing Amounts from the Member or their representative who has paid on the Member's behalf; or Pharmacy has otherwise waived the same Cost-Sharing Amounts for the Member or their representative who has paid on the Member's behalf;
3. In the event Pharmacy did collect a cost sharing amount from the Member or their representative who paid on the Member's behalf, and also received reimbursement from PBM, Pharmacy is required to reimburse the Member or their representative within 45 days of receiving the refund.
4. Pharmacy shall hold the debt for the amounts incorrectly charged to Members;
5. The amounts reimbursed are appropriate, owed and payable in accordance with applicable federal and state requirements;
6. Pharmacy shall retain the appropriate documentation and records to establish these certifications, including for purposes of an audit.

H. **Coverage Limitations**

a. A Drug is a Medicare Part D Drug if it is used for a medically accepted indication as defined in the Medicare regulations and implementing guidance. This definition includes prescribed uses supported by a citation included or approved for inclusion in one (1) of the following two (2) compendia:
   i. American Hospital Formulary Service-Drug Information (AHFS-DI)
   ii. DRUGDEX Information System

b. If the Drug is to be used for cancer, this definition includes prescribed uses supported by a citation included or approved for inclusion in one (1) of the following compendia or resources:
   i. American Hospital Formulary Service-Drug Information (AHFS-DI)
   ii. National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium • DRUGDEX Information System
   iii. Clinical Pharmacology
   iv. Lexi-Drugs
   v. One of the CMS approved peer reviewed literature sources

c. Based on the regulatory definitions, indications supported in peer reviewed medical literature are not "medically accepted" if they are not yet included, or approved for inclusion, in one of the compendia. Therefore, the use of a Drug Product for such indications would not meet the definition of a Medicare Part D Drug Product and the Drug Product would not be a Covered Prescription Service under the Benefit Plan, even if the Member's Prescriber states that the Drug Product is medically necessary.

d. The following additional coverage limitations may apply:
   i. Early refills for lost, stolen or destroyed Drug Products are not typically covered except during a declared "National Emergency." However, SCC 04 "Lost/Damaged Prescription" may be used for early refills for lost, stolen, damaged drug products and may be limited to number of fills and/or the number of day supplies per calendar year based on each client's Benefit Plan.
   ii. Early refills for vacation supplies may be limited to a one (1) time fill of up to thirty-one (31) days per calendar year according to Benefit Plan. If allowed under

each client's Benefit Plan, SCC 03 "Vacation Supply" may be used for early refills for vacation supplies.

iii. Early refills for increased doses for the same drug may be allowed under each client's Benefit Plan when SCC 05 "Therapy Change" is used.

iv. Drug Products will not be covered if prescribed by Prescribers that are excluded from Medicare program participation (unless they have an approved waiver on file with the OIG. These occurrences are very rare).

v. A Member may refill most Prescriptions when a minimum of seventy-five percent (75%) of the quantity is consumed based on the number of days supplied. This minimum quantity consumed amount is seventy percent (70%) for eye drops.

I. Medication Therapy Management (MTM)

Consistent with the Medicare Modernization Act (MMA) requirements for MTM, Medicare Part D Plan Sponsors provide MTM for eligible Members at no additional cost to the Members.
The MTM program is designed to ensure that medications are appropriately used to improve health outcomes and to reduce medication adverse events. A qualified health provider such as pharmacist performs this service.

a. MTM Eligibility

In order to qualify for these services, Medicare Plan Sponsors will identify these members based on their medical conditions, the number of medical conditions, the number of Part D medications, and the expected incurred annual cost of their Part D medications. Members part of a Drug Management Program (DMP) are considered as "at-risk beneficiaries (ARBs)" are also eligible for MTM. These measures may change annually based on Medicare guidance and will vary based on the Plan Sponsor. MTM criteria typically will be as follows, but specific details will be found on the member's Medicare Plan Sponsor's website.

- Member must have the specified minimum number of the following multiple chronic diseases
  - Alzheimer's Disease;
  - Chronic Heart Failure (CHF);
  - Diabetes;
  - Dyslipidemia;
  - End Stage Renal Disease (ESRD);
  - Hypertension
  - Respiratory diseases (such as Asthma, Chronic Obstructive Pulmonary disease (COPD), or Chronic Lung Disorders;
  - Bone Disease-arthritis (such as Osteoporosis, Osteoarthritis, or Rheumatoid Arthritis);
  - Mental Health (such as Depression, Schizophrenia, Bipolar disorder, or Chronic/Disabling Mental Health Conditions)
- Members must be taking a minimum of at least two to eight Part D medications
- Members are expected to meet or to exceed the annual Part D medication cost threshold. For calendar year 2022, the cost threshold is $4,696.
- Members that are part of a Drug Management Program (DMP) and are considered as "at-risk beneficiaries"

b. Scope of MTM Services

The scope of the MTM services will vary based on each Medicare Plan Sponsor, but at a minimum, will include all of the following as § 423.153(d)(1)(vii):

- Interventions for both members and prescribers
- An annual comprehensive medication review (CMR) with written summaries in CMS' Standardized Format under § 423.153(d)(1)(vii)(B) and (D)
- Quarterly targeted medication reviews (TMRs) with follow-up interventions when
- necessary as required at § 423.153(d)(1)(vii)(C).
- Information about safe disposal of prescription drugs that are controlled substances, drug take back programs, in-home disposal and cost-effective means to safely dispose of such drugs per § 423.153(d)(1)(vii)(E). This information must meet the criteria established in § 422.111(j).

c. **MTM Enrollment Process**
Eligible members are automatically identified for MTM based on their medication use and the Medicare Plan Sponsor's targeted conditions for the year. The MTM program is provided at no cost to eligible Medicare Part D members and they can opt-out at any time.

d. **MTM Reimbursement for Network Pharmacy Providers**
MTM contracting will vary based on each Medicare Plan Sponsor and how each is administering the MTM program. Reimbursements will be based on those contracts and whether or not network pharmacy providers are participating in those arrangements.

J. **Medicare Part D Transition Policy**

CMS requires Medicare Plan Sponsors to provide a temporary supply of some Part D drugs for certain members in order to avoid interruptions in drug therapy. Formulary Part D with coverage restrictions or non-formulary Part D drugs are eligible for transition. Members "new" to the Plan are eligible to receive transition supplies up to one month supply during the first ninety (90) days of initial membership. Existing members of a Plan will have transition benefits during the first ninety (90) calendar days of the year for any annual negative formulary changes that they utilize. If the prescription is for an unbreakable package, please refer to the Unbreakable Packages section. The prescription may be filled at a network pharmacy.

Notices for a transitional supply of a Drug will be provided to applicable Members and prescribers. These notices are sent by U.S. mail within three (3) business days of the temporary fill. It includes:

1. An explanation of the temporary nature of the transitional supply.
2. Instructions for working with the Plan and prescriber to identify appropriate formulary alternatives.
3. An explanation of the Member's right to request an exception.
4. A description of the procedures for requesting an exception.

Pharmacies may receive POS messaging for transition fill(s). After the transition supply ends, the Plan may require a coverage determination for continued coverage. Members are advised to discuss appropriate alternative therapies on the formulary with their prescriber. In the event there are no alternatives, the Member and prescriber may submit a coverage determination request. If an exception is approved, Members can obtain their drug for a specific period of time after their transition supply ends. The Plan may extend the transition supply period while the coverage determination is being processed and pursued.

Transition supply exceptions may also be allowed to address unplanned transitions such as due to hospital discharges or level-of-care changes. So as to allow time for Members to discuss alternative treatments with their prescriber or to pursue a coverage determination, Members

may request a level of care transition supply up to the Plan's month supply. Some Plans may also allow transition supply for these "unplanned transitions" through the use of submission clarification codes at point of sale.

K. **Medicare Part D Transitioning LTC Facility Residents**

CMS requires Medicare Plan Sponsors to provide a temporary supply of some Part D drugs for members residing in Long Term Care facilities. Eligible members receive transition fill(s) up to one month supply at any time during the first ninety (90) days of initial membership for new Members or the first (90) days of the calendar year for existing Members. If the prescription is for an unbreakable package, please refer to the Unbreakable Packages section.

If the LTC Member has been participating with the Plan for more than ninety (90) days and needs a Drug that is not on the formulary, has limited ability to acquire the Drug, or is pursuing a PA, the Plan may cover in cases of an emergency at least thirty-one (31) days or the Plan's month supply (whichever is greater) unless the prescription was written a shorter days' supply timeframe or the prescription is for an unbreakable package in which case please refer to the Unbreakable Packages section.

Transition supply exceptions may also be allowed to address unplanned transitions such as due to hospital discharges or level-of-care changes. So as to allow time for Members to discuss alternative treatments with their prescriber or to pursue a coverage determination, Members may request a level of care transition supply up to the Plan's month supply. Some Plans may also allow transition supply for these "unplanned transitions" through the use of submission clarification codes at point of sale.

L. **Unbreakable Packages Generally**

Drug Products in "unbreakable packages" must be dispensed in their original container/package and cannot be opened or broken. Please submit these Claims with a days' supply consistent with the dosing instructions on the Prescription and use the smallest package size when exceeding Plan Day Supply limitations. Note that Claims for Drug Products in unbreakable packages may be rejected if the days' supply submitted on the Claim is not consistent with dosing instructions or if it is not the smallest package size. Only the smallest and unbreakable package,will not be rejected if the days' supply is greater than Plan limitations.

If it's possible to submit a Claim with a smaller package size, the Claim may reject with "7X – Day's Supply > Plan Limitation." The Claim messaging will advise of next steps to process the Claim.

M. **Unbreakable Packages Medicare Part D**

Unbreakable package of transition eligible Part D Drug Products in its smallest packages that may be dispensed in excess of the limitations described in the "Medicare Part D transition policy" and the "Medicare Part D transitioning LTC facility residents" sections above. If the Member has remaining transition day supply, messaging may state "For CMS Transition, resubmit with remaining day supply of [#] or less." Resubmit the Claim with the smallest package size or fewest unbreakable packages that provides at least the transition day supply remaining.

N. **LTC Facility Information to be Provided Upon Termination**

In the event Pharmacy stops participating in an applicable network whether due to voluntary or involuntary termination or another reason, such Pharmacy is required to comply with the transition policies and procedures of applicable Plans. Pharmacy shall provide PBM with a list of LTC facilities to which it provides services for Members that are participating in Medicare Part D

Plans no later than five (5) business days following the notice of termination. Such list shall include the Pharmacy Name, Pharmacy NCPDP number, Pharmacy Address, LTC Facility Name, LTC Facility Address and LTC Facility Phone Number along with a Member list by Facility, including each Member's Name, ID number and date of birth.

O. **Short-Cycle-Dispensing (SCD) Processing for LTC**

CMS requires solid oral Brand Drugs to be dispensed in fourteen (14) days or less increments to Medicare Part D Members residing in LTC facilities. LTC Pharmacies may bill a short cycle claim for greater than a 14-day supply. However, you must dispense a short cycle prescription with a 14-day supply or less. This requirement is meant to reduce fraud, waste, and abuse by minimizing unused Drugs for the Medicare Part D program. Note that antibiotics in all forms, prepackaged Drugs and liquid Drugs formulations are exempt from this requirement. Member Cost-Sharing Amounts will be prorated based on the day supply.

When submitting Claims that are subject to the short-cycle regulations, providers must ensure that all of the following fields are submitted:

Pharmacy will receive one of the following rejection codes for Claims submitted with an invalid clarification code and special package indicator combination:

1. 597 — LTC dispensing type does not support packaging type
2. 613 — The packaging methodology or dispensing frequency is missing or inappropriate for LTC short-cycle
   The following fields must be completed on the Claim submission form:
   a. Patient qualification — patient residence
   b. Claim qualification — submission clarification code, special packaging type

The combination of values for these Claim qualifications are defined by CMS and NCPDP and are not user definable. If an NCPDP defined combination is not submitted correctly by the pharmacy, the Claim will be rejected with the 613 code.

If the LTC Pharmacy has submitted the Claim according to the above guidelines and receives a 597 code, then the LTC Pharmacy may resubmit the Claim with Submission Clarification Code 21 and SPI 1 or 3 to bypass the edit.

When submitting Claims that are subject to the short-cycle regulations, providers must ensure that all of the following fields are submitted:

Short-Cycle-Dispensing (SCD) Fields		
NCPDP Field Name	**NCPDP Field ID**	**Appropriate value(s) for SCD claims**
Patient Residence	384-4X	3
Submission Clarification Code	420-DK	Several valid values
Level of Service	418-DI	7
Special Packaging Indicator	429-DT	Several valid values

Short-Cycle-Dispensing Matrix

Submission Clarification Code 1 (420-DK)	Submission Clarification Code 2 (420-DK)	Special packaging indicator (429-DT)
14	21	1, 2, 3, 4, 5, 6, 7, OR 8
14	22	1, 2, 3, 4, 5, 6, 7, OR 8
14	23	1, 2, 3, 4, 5, 6, 7, OR 8
14	24	1, 2, 3, 4, 5, 6, 7, OR 8
14	25	1, 2, 3, 4, 5, 6, 7, OR 8
14	26	1, 2, 3, 4, 5, 6, 7, OR 8
14	27	1, 2, 3, 4, 5, 6, 7, OR 8
14	28	1, 2, 3, 4, 5, 6, 7, OR 8
14	29	1, 2, 3, 4, 5, 6, 7, OR 8
14	30	6, 7, OR 8
14	31	6, 7, OR 8
14	32	2, 3, 4, 5, 6, 7, OR 8
14	33	1, 2, 3, 4, 5, 6, 7, OR 8
14	34	1, 2, 3, 4, 5, 6, 7, OR 8
14	35	1, 2, 3, 4, 5, 6, 7, OR 8
14	36	1, 2, 3, 4, 5, 6, 7, OR 8
15	21	1, 2, 3, 4, 5, 6, 7, OR 8
15	22	1, 2, 3, 4, 5, 6, 7, OR 8
15	23	1, 2, 3, 4, 5, 6, 7, OR 8
15	24	1, 2, 3, 4, 5, 6, 7, OR 8
15	25	1, 2, 3, 4, 5, 6, 7, OR 8
15	26	1, 2, 3, 4, 5, 6, 7, OR 8
15	27	1, 2, 3, 4, 5, 6, 7, OR 8
15	28	1, 2, 3, 4, 5, 6, 7, OR 8
15	29	1, 2, 3, 4, 5, 6, 7, OR 8
15	30	6, 7, OR 8
15	31	6, 7, OR 8
15	32	2, 3, 4, 5, 6, 7, OR 8
15	33	1, 2, 3, 4, 5, 6, 7, OR 8

15	34	1, 2, 3, 4, 5, 6, 7, OR 8
15	35	1, 2, 3, 4, 5, 6, 7, OR 8
15	36	1, 2, 3, 4, 5, 6, 7, OR 8
17	21	1, 2, 3, 4, 5, 6, 7, OR 8
17	22	1, 2, 3, 4, 5, 6, 7, OR 8
17	23	1, 2, 3, 4, 5, 6, 7, OR 8
17	24	1, 2, 3, 4, 5, 6, 7, OR 8
17	25	1, 2, 3, 4, 5, 6, 7, OR 8
17	26	1, 2, 3, 4, 5, 6, 7, OR 8
17	27	1, 2, 3, 4, 5, 6, 7, OR 8
17	28	1, 2, 3, 4, 5, 6, 7, OR 8
17	29	1, 2, 3, 4, 5, 6, 7, OR 8
17	30	6, 7, OR 8
17	31	6, 7, OR 8
17	32	2, 3, 4, 5, 6, 7, OR 8
17	33	1, 2, 3, 4, 5, 6, 7, OR 8
17	34	1, 2, 3, 4, 5, 6, 7, OR 8
17	35	1, 2, 3, 4, 5, 6, 7, OR 8
17	36	1, 2, 3, 4, 5, 6, 7, OR 8
16		1, 2, 3, 4, 5, 6, 7, OR 8
18	16	1, 2, 3, 4, 5, 6, 7, OR 8
18	21	1, 2, 3, 4, 5, 6, 7, OR 8
18	22	1, 2, 3, 4, 5, 6, 7, OR 8
18	23	1, 2, 3, 4, 5, 6, 7, OR 8
18	24	1, 2, 3, 4, 5, 6, 7, OR 8
18	25	1, 2, 3, 4, 5, 6, 7, OR 8
18	26	1, 2, 3, 4, 5, 6, 7, OR 8
18	27	1, 2, 3, 4, 5, 6, 7, OR 8
18	28	1, 2, 3, 4, 5, 6, 7, OR 8
18	29	1, 2, 3, 4, 5, 6, 7, OR 8
18	30	6, 7, OR 8

18	31	6, 7, OR 8
18	32	2, 3, 4, 5, 6, 7, OR 8
18	33	1, 2, 3, 4, 5, 6, 7, OR 8
18	34	1, 2, 3, 4, 5, 6, 7, OR 8
18	35	1, 2, 3, 4, 5, 6, 7, OR 8
18	36	1, 2, 3, 4, 5, 6, 7, OR 8
22		1, 2, 3, 4, 5, 6, 7, OR 8
23		1, 2, 3, 4, 5, 6, 7, OR 8
24		1, 2, 3, 4, 5, 6, 7, OR 8
25		1, 2, 3, 4, 5, 6, 7, OR 8
26		1, 2, 3, 4, 5, 6, 7, OR 8
27		1, 2, 3, 4, 5, 6, 7, OR 8
28		1, 2, 3, 4, 5, 6, 7, OR 8
29		1, 2, 3, 4, 5, 6, 7, OR 8
30		6, 7, OR 8
31		6, 7, OR 8
32		2, 3, 4, 5, 6, 7, OR 8
33		1, 2, 3, 4, 5, 6, 7, OR 8
34		1, 2, 3, 4, 5, 6, 7, OR 8
35		1, 2, 3, 4, 5, 6, 7, OR 8

P. **Daily Cost Share (DCS)**

Claims that are submitted erroneously will be deemed non-Clean Claims and Pharmacy is responsible for all costs associated with such Claims. Pursuant to 42 CFR section 423.153(b)(4)(i), Medicare Part D Plans Sponsors are required to apply a DCS rate to certain covered Part D drugs when a network pharmacy dispenses for a supply less than the approved month's supply, if the drug is in the form of a solid oral dose and may be dispensed for less than the approved month's supply under applicable law, with some exceptions. Consequently, Medicare Part D Plan Sponsors may apply a prorated Cost Sharing Amount when the Drug meets the following condition:

- Does not have any of the listed daily cost share exclusions, and
- Is less than a month's supply, and
- Is a covered Part D drug, and
- Is a solid oral dose, and
- Has a member benefit copay design

Daily cost share will NOT be applied if any one of these exclusions exists:

- Non-part D drug
- Claim greater than or equal to a month's supply
- Antibiotics
- Compounds
- Vaccines
- Out of network claims
- Unbreakable products
- Member pays 100% of the cost of a claim
- Plan pays 100% of the cost of a claim

Some examples of where daily cost share logic may apply include, but not limited, to the following:

- Trial fills of less than a one (1) month supply
- Medication synchronization of Part D Drugs
- Long term care short cycle claim
- Opioid naïve 7 day supply or less claim
- Transition claims
- Emergency fills

Below are submitted clarification codes that may be used to override 'Refill Too Soon' rejections to synchronize fills related to DCS:

1. 47: Overrides Refill Too Soon for prorated Claims.
2. 48: Overrides the next Claim after the prorated Claim with a shortened supply to less days because of the prior Claim.
3. 61: Synchronization fill - A shortened days supply to align the dates of service across multiple medications.

Q. **Medicare Part D Notification of a Thirty (30) Day Negative Formulary Change**

Notice of negative formulary changes will be available online and communicated to Pharmacies at least thirty (30) days prior to the removal or adverse change in the preferred or tiered Cost Sharing status of a Medicare Part D Drug. Due to FDA market withdrawals, notifications may or may not be retrospective. The notification will include the Drug name affected, information around whether the Drug is being removed from the formulary of just having an adverse change in tiered Cost Share status, along with reason(s) why the Drug is being removed or changing status and alternative Drugs available in the same therapeutic category, class or Cost-Sharing tier, and the anticipated Cost Share amount for the Drug. Information around how Members may obtain updated coverage determinations or exceptions will also be provided.

R. **Medicare Part D Annual Notice of Change for Continuing Members**

Applicable Members receive an Annual Notice of Change (ANOC) packet from their Medicare Part D Plan Sponsor each year typically in the fall. This packet identifies any benefit changes to take effect on January 1st of the upcoming benefit plan year. If applicable, Members be eligible for a transition fill(s) if they were using a drug with negative formulary changes or are new to the Plan. Please see the Transition Policy outlined in this Provider Manual.

S. **Best Available Evidence (BAE)**

1. **Non-LTC Pharmacies**

In the event a Member has issues or questions their Cost Share Amount or states they are eligible for federal subsidy(ies) or help, such Member must provide valid supporting documentation in order to receive the lower Cost Share Amount. The following documents may be used as Best Available Evidence (BAE) to support the Member's qualification for federal subsidy(ies):

a. A copy of the beneficiary's Medicaid card that includes the beneficiary's name and an eligibility date during a month after June of the previous calendar year;
b. A copy of a state document that confirms active Medicaid status during a month after June of the previous calendar year;
c. A print out from the State electronic enrollment file showing Medicaid status during a month after June of the previous calendar year;
d. A screen print from the State's Medicaid systems showing Medicaid status during a month after June of the previous calendar year;
e. Other documentation provided by the State showing Medicaid status during a month after June of the previous calendar year; or,
f. For individuals who are not deemed eligible, but who apply and are found LIS eligible, a copy of the SSA award letter.

Accept any one of the following forms of evidence from beneficiaries or pharmacists to establish that a beneficiary is institutionalized and qualifies for zero cost-sharing:

g. A remittance from the facility showing Medicaid payment for a full calendar month for that individual during a month after June of the previous calendar year;
h. A copy of a state document that confirms Medicaid payment on behalf of the individual to the facility for a full calendar month after June of the previous calendar year; or
i. A screen print from the State's Medicaid systems showing that individual's institutional status based on at least a full calendar month stay for Medicaid payment purposes during a month after June of the previous calendar year.

If Pharmacy is provided with one of the documents listed above, Pharmacy shall contact the phone number of the back of the Member's ID card. If the documentation meets the BAE criteria, the Member's Cost Share Amount will be adjusted within forty-eight (48) to seventy-two (72) hours of receipt of BAE documentation. Pharmacy shall reprocess the Covered Prescription Service to capture the lower Cost Share amount. Please contact the phone number of the back of the Member's ID card with any questions related to this BAE process.

2. **LTC Providers Only**

In the event a Member has issues or questions their Cost Share Amount or states they are eligible for the institutional status zero (0) Cost Share Amount, such Member must provide valid supporting documentation in order to receive the zero (0) Cost Share amount. The following documents may be used as Best Available Evidence (BAE) to support the Member's institutional status and qualification for zero (0) Cost-Sharing:

a. A remittance from the facility showing Medicaid payment for a full calendar month for the beneficiary during a month after June 30 of the previous calendar year;
b. A copy of the state document that confirms Medicaid payment for a full calendar month for the beneficiary during a month after June 30 of the previous calendar year;
c. A screen print from the State's Medicaid systems showing the beneficiary's institutional status for at least a full calendar month stay for Medicaid payment purposes during a month after June 30 of the previous calendar year.

If a Member's subsidy level needs to be corrected utilizing BAE, Pharmacy must receive one (1) of the documents listed above from the Member and contact the phone number of the back of the Member's ID card.

If the documentation provided meets the criteria required for BAE, the Member's Cost Share will be adjusted between forty-eight (48) to seventy-two (72) hours of receipt of the documentation. Pharmacy must reprocess the Drug to get the lower Cost Share amount. Please contact the phone number of the back of the Member's ID card if assistance is needed.

T. Medicare Part D Home Delivery (Mail Order or Automatic Delivery)

1. Initial/New Prescriptions

Per guidance from CMS, if Pharmacy is contracted to provide mail order or other home delivery programs, Pharmacy is required to obtain the Member or the Member's authorized representative consent prior to delivery if the prescription was electronically transmitted directly to the Pharmacy and the Member has not previously received a Mail order or home delivery service with the Pharmacy.

If the prescription was submitted via paper by the Member or Member's authorized representative to the Pharmacy, separate consent is not required as the paper submission means the Member is choosing to have the Drug filled at the Pharmacy (i.e. submitted a paper prescription demonstrates consent).

Documentation showing the Member's or their authorized representative's consent to fill the prescription or a history of mail order or home delivery must be maintained by Pharmacy and made available to the PBM or Medicare Part D Sponsor upon request.

If the Pharmacy is dispensing Part B covered products to a Medicare Advantage Plan Member who also has Medicaid (a.k.a. traditional Medicaid (including SLMB+)), but that Member is not located in the same state as the Pharmacy, then the Part B copay may not be collected from the Member if they have qualifying Medicaid coverage for the product whether or not the Pharmacy is contracted with the Member's applicable Medicaid plan.

2. Refill Prescriptions

Per guidance from CMS, use of mail order or any auto-ship/auto-refill arrangements within Part D cannot be mandatory. If Pharmacy is contracted to provide mail order or other home delivery programs, Pharmacy is required to obtain the Member or the Member's authorized representative consent prior to delivery. Consent must be received from the Member after an initial fill of a new drug to activate auto-ship for any subsequent refills of that drug. Consent to auto-ship a specific drug may not be assumed or activated at the same time as an initial fill, allowing time for the Member to initiate therapy and determine whether treatment with the new drug is tolerated and to be continued. Consent to auto-ship a specific drug may not be assumed or activated at the same time as an initial fill o Pharmacy requires enrollees to opt-in to auto-ship refills on a drug-by-drug basis. A Member's voluntary selection of auto-ship for a specific drug implies a preference to have auto-shipped all refills authorized by the prescription order, unless or until they, their prescriber, or an authorized representative opts-out of that prescription (e.g., cancels auto-ship, cancels an order prior to shipping, or reports an order as unwanted after shipping). If a prescriber renews a prescription for an existing drug therapy, the auto-ship program may extend the previous Member consent to auto-ship the new prescription order and its authorized refills, unless instructed otherwise. Note that Members are allowed to opt-out of the auto-ship program at any time. For refills, Members are to receive a minimum of two shipping reminders, to include all relevant information,

including the name of the drug, applicable Cost Sharing Amount and how to cancel the order prior to shipping. Pharmacy must promptly discontinue automatic deliveries after information becomes available from CMS, the Member, their prescriber, or an authorized representative that the Member has entered a skilled nursing facility or elected hospice coverage.

Documentation showing the Member's or their authorized representative's consent to fill the prescription or a history of mail order or home delivery must be maintained by Pharmacy and made available to the PBM or Medicare Part D Sponsor upon request.

U. Dual Eligible Members Medicare Part B Cost Sharing and Prohibition of Balance Billing

Those health plans that are Medicare Advantage Plans (a.k.a. MAPD or Part C) are insurance plans approved by CMS and administrated by private companies that take the place of and combine Medicare benefits from Parts A (hospital), B (medical), and D (prescription drug). Members that are Dual Eligible are Medicare beneficiaries who are also eligible for some level of Medicaid assistance. Most State Medicaid programs have a legal obligation to pay Medicare cost-sharing (deductible, copay or coinsurance) for these Dual Eligible individuals.

When Medicare providers try to bill Qualified Medicare Beneficiaries (QMBs) for Medicare cost share or copay amounts, such practice is called balance billing and is strictly prohibited by CMS. Note contracted Medicare physicians and pharmacies, including those providing services to MAPD Members (i.e. MAO, MAPD/Part C or Managed Care), are strictly prohibited from balance billing these Members. If the Member is QMB, the Medicare cost share is required to be submitted to Medicaid and the reimbursement amount must be accepted as payment in full regardless of the amount. Any Medicaid copays may be collected from the Member. Inability to submit a claim whether due to noncontracted status or systematic issues is not a valid reason to collect the Medicare cost share amounts from the applicable Member. In the event electronic secondary billing is not allowed for Medicare Advantage Members, please contact Medicaid to determine how to properly bill the Medicare cost share. Pharmacies who balance bill may be penalized (as established in Section 1902(n)(3)(C) of the Social Security Act) and/or terminated from the pharmacy network.

As many Medicaid agencies cover all or a portion of the Medicare cost share for Members that have full Medicaid even if they are not QMB, Pharmacy is advised to verify and coordinate Medicaid benefits appropriately. Pharmacies are required to bill Medicaid for the Medicare cost share if the Member has qualifying Medicaid coverage as well.

V. Medicaid Dual Status Codes and Medicare Cost Share Coverage

1. CMS 01 Partial Dual – QMB only (Qualified Medicare Beneficiary): Must bill Medicaid for Medicare copay – no exceptions. CMS strictly prohibits Balance Billing.
2. CMS 02 Full Dual – QMB+ (Qualified Medicare Beneficiary plus Full Medicaid): Must bill Medicaid for Medicare copay – no exceptions. CMS strictly prohibits Balance Billing.
3. CMS 03 Partial Dual – SLMB only (Specified Low Income Medicare Beneficiary): Medicare copay not covered by Medicaid; copay is Member responsibility.
4. CMS 04 Full Dual – SLMB+ (Specified Low Income Medicare Beneficiary plus Full Medicaid): Conditional – Verify Medicaid DME benefits and bill Medicaid for the Medicare copay when covered.
5. CMS 05 Partial Dual – QDWI (Qualified Disables and Working Individuals): Medicare copay not covered by Medicaid; copay is Member responsibility.
6. CMS 06 Partial Dual – QI (Qualified Individual): Medicare copay not covered by Medicaid; copay is Member responsibility.

7. CMS 08 Full Dual – Full Medicaid Benefit Dual Eligible: Conditional—Verify Medicaid DME benefits and bill Medicaid for the Medicare copay when covered.

   As a reminder, network providers shall comply with all state and federal laws and regulations.

W. **Dual Eligible Members and Part B Drugs**

Some Medicare Part B covered drugs or diabetic supplies may be submitted via POS under the Medicare Part D BIN/PCN which will allow Pharmacy to identify Medicare Part B claims and Dual Eligible Members who have coverage for the Medicare Part B copay.

1. Benefit Stage Qualifier field (BSQ) will be populated with value 51 on the pricing segment response (D.0 Field #393-MV) when a Medicare Advantage Member receives a Medicare Part B covered service and CMS has notified the plan that QMB (Qualified Medicare Beneficiary) or full Medicaid coverage exists.
   i. When BSQ value 51 is present, the pharmacy must refrain from collecting the copay from the Member - otherwise known as "Balance Billing."
   ii. An additional alert may be provided via local claims messaging stating CMS Medicaid Status Code and partial or full Dual status (see chart on above): "Part B claim; If BSQ=51, bill Medicaid for copay. Balance Billing prohibited."
2. If a Member indicates they have QMB or full Medicaid coverage, but BSQ value is not 51, Pharmacy should contact the Member's State Medicaid or the number on the back of the Member's ID card to verify status.
3. Pharmacy should bill Medicaid for the remaining Medicare Part B copay or balance. If Medicaid imposes a Medicaid copay after they process the Medicare Part B secondary claim, the pharmacy may collect this amount from the Member.
4. Medicaid is always the payer of last resort and should never be billed as primary to circumvent coordination of benefits with the Medicare Advantage Plan.

X. **Medicare Supplier Number**

Pursuant to 42 CFR § 424.57, Pharmacy is advised to obtain and maintain for each Pharmacy a Medicare Part B supplier number and update applicable information in the NCPDP database to capture the assigned numbers. PBM shall use the information in the NCPDP database to identify those pharmacies with Medicare Part B supplier numbers in the pharmacy network directories.

Y. **Medicare Notice of Patient's Rights**

Pharmacy is required to comply with all CMS regulations regarding the provision of written notices to Medicare Members. In order to indicate compliance, Pharmacy must:

1. Demonstrate and provide documentation that outlines the process by which each Member receives the communication entitled Notice of Patient Rights (CMS document 10147) during each rejection (rejection type 569);
2. Display the sign in the Pharmacy waiting area;
3. Notify a Member of a Claim rejection if the Member is not physically present at the Pharmacy and letting the Member know they can receive the Medicare Notice of Rights at the Pharmacy or through the mail.

Z. **Compliance**

All Medicare Plans (including MAO, MMP, MCO plans) are required to have a compliance plan that meets all applicable regulatory requirements (42 CFR Parts 422 and 423). Such compliance plan must be reasonably designed, implemented, and enforced to be effective in preventing, as well as detecting noncompliance with regulatory requirements. The plan must address program-

specific requirements and address preventing/detecting potential criminal/fraudulent conduct. PBM has a compliance plan in place which aligns with Federal Sentencing Guidelines and supports the monitoring/detection of FWA (fraud, waste and abuse) within federal programs.

AA. Medicare Part D Specific Concurrent Drug Utilization Review (CDUR) Edits

In addition to CDUR edits previously outlined in the Drug Utilization Review section of the Provider Manual, CMS requires Plan Sponsors to implement several strategies to prevent and combat opioid overuse. These real-time safety edits occur at point of sale and engage patients and healthcare providers to address opioid overdose risks. Some members will be exempt from these edits at point of sale if they have cancer, Sickle Cell Anemia, under hospice or palliative care, or reside in a long term care facility.

Medicare Part D Opioid Safety Edits	
90 Morphine Milligram Equivalent (MME) Care Coordination Edit	Point of sale care coordination safety edit that rejects opioid claims at ≥ 90 MME when a minimum number of opioid prescribers and pharmacy counts are met within a defined lookback period
Hard Opioid Edit	Point of sale care coordination safety edit that rejects opioid claims at specified MME that is at a minimum of 200 when a minimum number of opioid prescribers and pharmacy counts are met within a defined look back period
Opioid Naïve 7 Day Supply Edit	Point of sale safety edit that reject opioid day supply is greater than 7 for opioid naïve members
Duplicative Opioid Therapy	Point of sale safety edit that rejects long-acting opioid claim if filled within window of another long-acting opioid claim. Medicare Plan Sponsors can optionally implement duplicative short acting opioids
Concurrent use of Opioid and Benzodiazepine	Point of sale safety edit that rejects opioid claim if filled within a defined look back period of another benzodiazepine claim. Edit will also reject benzodiazepine claim if filled with a defined look back period of another opioid claim
Opioids with Acetaminophen greater than a 4000 mg Max Daily Dose	Point of sale safety edit that rejects claims with products containing APAP if cumulative daily dose is > 4000 mg per day
Concurrent use of Opioid and Medication Assisted Treatment (MAT)	Point of sale safety edit that rejects opioid claims after filling a MAT drug
Naloxone Co-prescribing Message	Point of sale messaging on any adjudicated paid opioid claim when opioid ≥ 50 MME

When these edits are triggered, a claim may reject and prompting prescribers and pharmacists to conduct additional safety review to determine if the enrollee's opioid use is appropriate and medically necessary. These edits may trigger during a member's transition period and multiple edits may be triggered concurrently.

Once the pharmacists have clinically reviewed the reject or performed care coordination activities, and determines that the dispensing of the medication is safe and medically necessary,

the appropriate drug utilization review professional pharmacy service (DUR/PPS) override codes may be sent along the claim to bypass the reject. DUR/PPS service override codes are provided below for the corresponding edit.

If the pharmacist determines chooses not to dispense the opioid medication due to their clinical judgement, pharmacy must distribute a written copy of the standardized CMS pharmacy notice to the member ("Medicare Prescription Drug Coverage and Your Rights," CMS-10147, OMB Approval No. 0938-0975). This notice instructs members on how to contact their Plan and explains their right to obtain a coverage determination from the Plan, including information about the exceptions process.

Medicare Part D Opioid Safety Edits DUR/PPS Service Override Codes

Opioid Edit	Reason for Service Code (439-E4)	Professional Service Code (440-E5)	Result of Service Code (441-E6)
90 Morphine Milligram Equivalent (MME) Care Coordination Edit	HC - High Cumulative Dose	CC Coordination of Care DP Dosage Evaluated DE Dosage Evaluation/Determination M0 Prescriber Consulted MR Medication Review R0 Pharmacist Consulted Othr	1A Dispensed As Is, False Positive 1B Dispensed Prescription As Is 1C Dispensed, With Different Dose 1D Dispensed, With Different Directions 1E Dispensed, With Different Drug 1F Dispensed, With Different Quantity 1G Dispensed, With Prescriber Approval 3D Regimen Changed 3E Therapy Changed 3G Drug Therapy Unchanged 4A Prescribed With Acknowledgments 4B Dispensed, Palliative Care 4C Dispensed, Hospice 4D Dispensed, Cancer Treatment 4E Dispensed, Chronic Pain 4F Dispensed, Exempt Per Prescriber 4G Dispensed, Surgery/Trauma 4H Dispensed, Hospital Admission/Discharge 4K Prescriber Exempt – Cancer/Palliative Care 4L Prescriber Exempt – Hospice
Hard Opioid Edit	HC - High Cumulative Dose	M0 Prescriber Consulted R0 Pharmacist Consulted Othr	4B Dispensed, Palliative Care 4C Dispensed, Hospice 4D Dispensed, Cancer Treatment 4K Prescriber Exempt – Cancer/Palliative Care 4L Prescriber Exempt – Hospice
		MR Medication Review	4D Dispensed, Cancer Treatment
Opioid Naïve 7 Day Supply Edit	MX - Excessive Duration Alert	M0 Prescriber Consulted R0 Pharmacist Consulted Othr	4B Dispensed, Palliative Care 4C Dispensed, Hospice 4D Dispensed, Cancer Treatment 4J Dispensed, Pt Not Opioid Naïve 4K Prescriber Exempt – Cancer/Palliative Care 4L Prescriber Exempt – Hospice
		MR Medication Review	4D Dispensed, Cancer Treatment 4J Dispensed, Pt Not Opioid Naïve
Duplicative Opioid Therapy	TD - Therapeutic Duplication	CC Coordination of Care DP Dosage Evaluated DE Dosage Evaluation/Determination M0 Prescriber Consulted MR Medication Review R0 Pharmacist Consulted Othr	1A Dispensed As Is, False Positive 1B Dispensed Prescription As Is 1C Dispensed, With Different Dose 1D Dispensed, With Different Directions 1E Dispensed, With Different Drug 1F Dispensed, With Different Quantity 1G Dispensed, With Prescriber Approval 3D Regimen Changed 3E Therapy Changed 3G Drug Therapy Unchanged

			4A Prescribed With Acknowledgments 4B Dispensed, Palliative Care 4C Dispensed, Hospice 4D Dispensed, Cancer Treatment 4E Dispensed, Chronic Pain 4F Dispensed, Exempt Per Prescriber 4G Dispensed, Surgery/Trauma 4H Dispensed, Hospital Admission/Discharge 4K Prescriber Exempt – Cancer/Palliative Care 4L Prescriber Exempt – Hospice
Concurrent use of Opioid and Benzodiazepine	DD - Drug-Drug Interaction	CC Coordination of Care DP Dosage Evaluated DE Dosage Evaluation/Determination M0 Prescriber Consulted MR Medication Review R0 Pharmacist Consulted Othr	1A Dispensed As Is, False Positive 1B Dispensed Prescription As Is 1C Dispensed, With Different Dose 1D Dispensed, With Different Directions 1E Dispensed, With Different Drug 1F Dispensed, With Different Quantity 1G Dispensed, With Prescriber Approval 3D Regimen Changed 3E Therapy Changed 3G Drug Therapy Unchanged 4A Prescribed With Acknowledgments 4B Dispensed, Palliative Care 4C Dispensed, Hospice 4D Dispensed, Cancer Treatment 4E Dispensed, Chronic Pain 4F Dispensed, Exempt Per Prescriber 4G Dispensed, Surgery/Trauma 4H Dispensed, Hospital Admission/Discharge 4K Prescriber Exempt – Cancer/Palliative Care 4L Prescriber Exempt – Hospice
Opioids with Acetaminophen greater than a 4000 mg Max Daily Dose	HC - High Cumulative Dose	CC Coordination of Care DP Dosage Evaluated DE Dosage Evaluation/Determination M0 Prescriber Consulted MR Medication Review R0 Pharmacist Consulted Othr	1A Dispensed As Is, False Positive 1B Dispensed Prescription As Is 1C Dispensed, With Different Dose 1D Dispensed, With Different Directions 1E Dispensed, With Different Drug 1F Dispensed, With Different Quantity 1G Dispensed, With Prescriber Approval 3D Regimen Changed 3E Therapy Changed 3G Drug Therapy Unchanged 4A Prescribed With Acknowledgments 4B Dispensed, Palliative Care 4C Dispensed, Hospice 4D Dispensed, Cancer Treatment 4E Dispensed, Chronic Pain 4F Dispensed, Exempt Per Prescriber 4G Dispensed, Surgery/Trauma 4H Dispensed, Hospital Admission/Discharge 4K Prescriber Exempt – Cancer/Palliative Care 4L Prescriber Exempt – Hospice
Concurrent use of Opioid and Medication Assisted Treatment (MAT)	MC - Drug-Disease	CC Coordination of Care DP Dosage Evaluated DE Dosage Evaluation/Determination M0 Prescriber Consulted MR Medication Review R0 Pharmacist Consulted Othr	1A Dispensed As Is, False Positive 1B Dispensed Prescription As Is 1C Dispensed, With Different Dose 1D Dispensed, With Different Directions 1E Dispensed, With Different Drug 1F Dispensed, With Different Quantity 1G Dispensed, With Prescriber Approval 3D Regimen Changed 3E Therapy Changed 3G Drug Therapy Unchanged 4A Prescribed With Acknowledgments 4B Dispensed, Palliative Care 4C Dispensed, Hospice 4D Dispensed, Cancer Treatment 4E Dispensed, Chronic Pain 4F Dispensed, Exempt Per Prescriber 4G Dispensed, Surgery/Trauma 4H Dispensed, Hospital Admission/Discharge 4K Prescriber Exempt – Cancer/Palliative Care 4L Prescriber Exempt – Hospice

BB. **Medicare Drug Management Program (DMP)**

Beginning in 2022, Medicare Plan Sponsors are required to provide a Drug Management Program (DMP). The program identifies members that may be inappropriately using opioids based on a member's average daily morphine milligram equivalent (MME) for the past 6 months, number of unique opioid prescribers, number of unique dispensing pharmacies, or if a member has had an opioid related overdose.

Once at-risk members are identified, Medicare Plan Sponsors will work with the member's prescriber(s) to determine if limiting the member's access to specific frequently abused drugs (FAD's), such as opioid or benzodiazepine medications, is warranted. If a prescriber agrees to proceeding with case management, the member's access to FAD will be limited to the type of FAD, to the quantity or dose of the FAD, to specific prescribers of FAD, or to specific pharmacies. A prescriber may want to limit any number or any of these combinations.

Prescribers and members will be notified of the limit and the type of limit in advance. Pharmacies may receive the following rejects if a member is under a DMP. The member must fill their FAD as specified in their notice in order to be covered. If network pharmacies have any questions about rejected claims or issues due to DMP, please contact the pharmacy help desk number located on the Member ID card.

- 828 - Plan/Beneficiary Case Management Restriction In Place
- 943 - DUR Reject – Pharmacy Override Using DUR/PPS Not Allowed
- 979 - Patient Locked Into Specific Prescriber(s)
- 980 - Patient Locked Into Specific Pharmacy(s)

CC. **Medicare Part D Drug Management Program Member Pharmacy Lock-In Edit**

Per Section 1860D-4(c)(5)(A) of the Social Security Act, Part D plans are required to establish a Drug Management Program as of January 1, 2022.

The Medicare Part D Drug Management Program (DMP) identifies members who are using high doses of opioids that are prescribed by multiple prescribers and/or filled at multiple pharmacies and/or those that have had a recent opioid related overdose. Per CMS, all prescribers of a group practice are considered one prescriber and pharmacies with multiple locations that share real-time electronic data are considered one pharmacy. *See* 42 C.F.R. § 423.153(f)(12)(ii).

Members who are identified as potentially at risk for abuse or misuse of opioids are case managed by an assigned clinical pharmacist and medical director at Capital Rx. When needed, the pharmacist outreaches to the prescribers to verify medical necessity of the current opioid usage and to obtain agreement to lock-in the member to a prescriber, pharmacy, and/or drug.

Pharmacies that are contracted with Capital Rx will participate in the pharmacy lock-in component of the Drug Management Program (DMP), which applies to the Pharmacy.

Capital Rx reserves the right to add, delete, or modify the policies associated with the lock-in program. Pharmacies shall be deemed participating in all components associated with the DMP pharmacy lock-in limitation and may not terminate or refuse participation. Capital Rx will let Pharmacies know when a Member will be locked in for coverage of their opioid and frequently abused medications in writing or by telephone, in the event communication in writing is not feasible, before the edit takes effect. Pharmacies in network agree to accept pharmacy lock-in selections made on behalf of Capital Rx for members identified by DMP. In doing so, pharmacies

in network do not need to provide confirmation back to Capital Rx each time they are notified about a pharmacy lock-in decision for a member. Pharmacies that are not in-network but have been selected to be the designated pharmacy in a lock-in will receive notification in writing or by telephone, in the event communication in writing is not feasible, and will need to send back a response form confirming acceptance of the Member pharmacy lock-in edit.

Capital Rx cannot implement a prescriber lock-in without obtaining an agreement from the prescriber(s) first during the course of case management. Prescribers will be notified of their Member's prescriber lock-in via receiving a copy of the Member Initial Notice, which will contain a cover letter addressed to the prescriber to provide a summary of the case management decision.

DD. **Performance and Service Criteria for Network Long-Term Care Pharmacies (NLTCP)**

a. Comprehensive Inventory and Inventory Capacity – The pharmacy must provide a comprehensive inventory of plan formulary drugs commonly used in the long-term care setting maintained within a secured area for physical storage of drugs, with necessary added security as required by Federal and State law for controlled substances.
b. Pharmacy Operations and Prescription Orders – The pharmacy must provide services of a dispensing pharmacist to meet the requirements of pharmacy practice for dispensing prescription drugs to LTC residents, including but not limited to the performance of drug utilization review (DUR).
c. Special Packaging – The pharmacy must have the capacity to provide specific drugs in units of use packaging, bingo cards, cassettes, unit dose or other special packaging commonly required by LTC facilities.
d. Intravenous (IV) Medications – The pharmacy must have the capacity to provide IV medications to the LTC resident as ordered by a qualified medical professional and must have access to specialized facilities for the preparation of IV prescriptions (clean room).
e. Compounding/Alternative Forms of Drug Composition – The pharmacy must be capable of providing specialized drug delivery formulations as required for some LTC residents. Specifically, residents unable to swallow or ingest medications through normal routes may require tablets split or crushed or provided in suspensions or gel forms, to facilitate effective drug delivery.
f. Pharmacist On-call Service – The pharmacy must provide on-call, 24-hour-per-day/7-day-a-week service with a qualified pharmacist available for handling calls after hours and to provide medication dispensing available for emergencies, holidays and after hours of normal operations.
g. Delivery Service – The pharmacy must provide for delivery of medications to the LTC facility up to 7 days each week (up to 3 times per day) and in-between regularly scheduled visits. Emergency delivery service must be available 24 hours a day, 7 days a week.
h. Emergency Boxes – The pharmacy must provide "emergency" supply of medications as required by the facility in compliance with State requirements.
i. Emergency Log Books – The pharmacy must provide a system for logging and charging medication used from emergency/first dose stock. Further, the pharmacy must maintain a comprehensive record of a resident's medication order and drug administration.
j. Miscellaneous Reports, Forms and Prescription Ordering Supplies – The pharmacy must provide reports, forms and prescription ordering supplies necessary for the delivery of quality pharmacy care in the LTC setting.
k. Post-Consumption Billing (Section 50.5.5) - certain LTC pharmacies utilize post-consumption billing procedures. Post-consumption billing arrangements are permissible

under the Part D program and should be accommodated by sponsors, assuming they are managed in a manner that is compatible with all other Part D requirements.

Appendix C

Medicaid Information

New Mexico

Centennial Care Regulatory Requirements Exhibit

This New Mexico Centennial Care Regulatory Requirements Exhibit (this "NM Exhibit") supplements and is made a part of the provider agreement (the "Agreement") between Capital Rx Inc. ("Subcontractor") and the provider named in the Agreement ("Provider").

I. Applicability. This NM Exhibit applies with respect to the provision of health care services that Provider provides directly to Covered Persons through Health Plan's (as defined herein) products or benefit plans including the State of New Mexico Centennial Care program (the "Centennial Care Program," as further defined below) as governed by the State's designated regulatory agencies. Provider has agreed to provide Covered Services to Covered Persons who receive their coverage pursuant to a contract between the State and Health Plan (the "Centennial Care Contract" as defined herein). The Centennial Care Contract and applicable State and federal law require that the provisions contained in this NM Exhibit be part of the Agreement. In the event of a conflict between this NM Exhibit and other appendices or any provision of the Agreement, the provisions of this NM Exhibit shall control except with regard to benefit contracts outside the scope of this NM Exhibit or unless otherwise required by law. In the event Subcontractor is required to amend or supplement this NM Exhibit as required or requested by the State and requested by Health Plan, Provider agrees that Subcontractor shall be permitted to unilaterally initiate such additions, deletions or modifications.

II. Definitions. Unless otherwise defined in this NM Exhibit, all capitalized terms shall be as defined in the Agreement. For purposes of this NM Exhibit, the following terms shall have the meanings set forth below; provided, however, in the event any definition set forth in this NM Exhibit or the Agreement is inconsistent with any definitions under the Centennial Care Program, the definitions shall have the meaning set forth under the Centennial Care Program. 2.1

1. Collaborative: The New Mexico Behavioral Health Purchasing Collaborative.
2. Centennial Care Contract: Health Plan's contract with the New Mexico Human Services Department and Collaborative for the purpose of providing and paying for Covered Services to Covered Persons enrolled in the Centennial Care Program.
3. Centennial Care Program: The State of New Mexico's Medicaid program operated under section 1115(a) of the Social Security Act waiver authority, which is a Medicaid managed care program that is a joint initiative of HSD and Collaborative. For purposes of this NM Exhibit, Centennial Care Program may refer to the State agency(ies) responsible for administering the Centennial Care Program. The Centennial Care Program includes Centennial Care 2.0 and any successor program.
4. Covered Person: An individual who is currently enrolled with Health Plan and/or Subcontractor for the provision of Covered Services. A Covered Person may also be referred to as an Enrollee, Member, Customer or other similar term under the Agreement.
5. Covered Services: Health care services or products for which a Covered Person is enrolled with Health Plan and/or Subcontractor to receive coverage under a contract with the State, including the Centennial Care Contract.

6. Health Plan: An appropriately licensed entity that has entered into a contract with Subcontractor, either directly or indirectly, under which Subcontractor provides certain administrative services for Health Plan pursuant to the State Contract.
7. Human Services Department ("HSD"): The administrative agency within the executive department of New Mexico State government established under Chapter 9, New Mexico Statutes Annotated 1978, or its designee, including but not limited to agencies of the New Mexico Human Services Department.
8. Provider: An individual provider, clinic, group, association or facility that is qualified and appropriately licensed to provide health care services to individuals enrolled in Medicaid or the Centennial Care Program and that has entered into an Agreement or is subject to and renders Covered Services under an Agreement for such services.
9. State: The State of New Mexico or its designated regulatory agencies, including specifically HSD and/or Collaborative, as applicable throughout this Appendix.

III. Provider Requirements. The Centennial Care Program, through contractual requirements and federal and State statutes and regulations, requires the Agreement to contain certain requirements that Health Plan, Subcontractor, and Provider agree to undertake, which include the following:

1. Covered Service Definitions. Provider shall follow the Centennial Care Contract's provisions for the coverage 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:
    a) Emergency Medical Condition: A medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical care to result in any of the following: (1) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; (3) serious dysfunction of any body organ or part; or (4) serious disfigurement to the individual.
    b) Emergency Services: Covered inpatient and outpatient services that are as follows: (1) furnished by a provider qualified to furnish these health services; and (2) needed to evaluate or stabilize an Emergency Medical Condition. Emergency Services shall be provided to Covered Persons without the requirement of prior authorization of any kind pursuant to 42 CFR § 438.114.
    c) Medically Necessary Services: Clinical and rehabilitative physical, mental or behavioral health services that are: (1) essential to prevent, diagnose or treat medical conditions or are essential to enable the Covered Person to attain, maintain or regain optimal functional capacity; (2) delivered in the amount, duration, scope and setting that is both sufficient and effective to reasonably achieve their purposes and clinically appropriate to the specific physical, mental and behavioral health care needs of the Covered Person; (3) provided within professionally accepted standards of practice and national guidelines; and (4) required to meet the physical, mental and behavioral health needs of the Covered Person and (5) are not primarily for the convenience of the Covered Person, Provider, Health Plan, or Subcontractor.
2. Medicaid or CHIP Participation. Provider must be enrolled with the State as a Medicaid or CHIP provider, as applicable to participate in Health Plan's Medicaid or CHIP network. Upon notification from the State that Provider's enrollment has been denied or terminated, Subcontractor and Health Plan must terminate Provider immediately and will notify affected Covered Persons that Provider is no longer participating in the network.

Subcontractor and Health Plan will exclude from its network any provider who has been terminated or suspended from the Medicare, Medicaid or CHIP program in any state.

3. Appointment Access. Provider shall provide for timely access to Covered Person appointments in accordance with the appointment availability requirements established under the Centennial Care Contract, including without limitation, appointments for preventive care, urgent care, routine sick care, and well care.
4. Hours of Operation. Provider shall offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service if Provider serves only Medicaid beneficiaries. As applicable, Provider will make Covered Services available 24 hours a day, 7 days a week when medically necessary.
5. Information to Covered Persons. Provider shall provide information to Covered Persons regarding treatment options, including the option of no treatment, in a culturally competent manner and shall ensure that individuals with disabilities have effective communications in making decisions regarding treatment options, pursuant to the requirements of the Centennial Care Contract or as otherwise may be required by law.
6. Primary Care. If Provider is a primary care physicians ("PCP"), Provider shall comply with the PCP requirements set forth in the Centennial Care Contract.
7. Unique Identifier. Providers billing or rendering services to Covered Persons shall have a unique identifier in accordance with the provisions of Section 1173(b) of the Social Security Act.
8. Records. Provider shall maintain an adequate record keeping system for recording services, charges, dates and all other commonly accepted information elements for services rendered pursuant to the Centennial Care Contract. Provider shall also comply, with the following requirements related to maintenance and retention of records:
    a) Financial Records. Provider shall maintain records, books, documents, and information that are adequate to ensure that services are provided and payments are made in accordance with the requirements of the Centennial Care Contract, including applicable federal and State requirements.
        i. Providers shall retain records for a period of ten (10) years after Centennial Care Contract is terminated or until the resolution of all litigation, Claims, financial management reviews or audits pertaining to the Centennial Care Contract, whichever is longer.
    b) Retention and Access to Records:
        i. Provider shall retain records and reports relating to services provided to Covered Persons Contract, including records and reports of services provided to Covered Persons, for a minimum of ten (10) years after final payment. In cases involving incomplete audits or unresolved audit findings, administrative sanctions, or litigation, the minimum ten (10) year period shall begin on the date such actions are resolved.
        ii. Provider shall maintain appropriate records in accordance with federal and State statutes and regulations relating to Health Plan's performance under the Centennial Care Contract, including but not limited to records relating to services provided to Covered Persons, including a separate medical record for each Covered Person. Each medical record shall be maintained on paper and/or in electronic format in a manner that is timely, legible, current and organized, and that permits effective and confidential patient care and quality review.
        iii. Provider shall make all Covered Person medical records or other service records available for the purpose of quality review conducted by the State or its designated agents both during and after the Contract period.

iv. Government Audit and Inspection. Provider acknowledges and agrees that the State, CMS, the Office of Inspector General, the Comptroller General, and the U.S. Department of Health and Human Services and their designees or their authorized representatives shall at any time, have the right to inspect, audit or otherwise evaluate the quality, appropriateness, and timeliness of services provided under the terms of the State Contract and any other applicable rules, including the right to inspect and audit any records or documents of Provider and its subcontractors, and the right to inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted. The right to audit under this section exists for 10 years from the end date of the State Contract or from the date of completion of any audit, whichever is later. There shall be no restrictions on the right of the State or federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness or timeliness of services provided pursuant to the State Contract and the reasonableness of their costs.

9. Privacy. 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 and maintain the confidentiality of information about Covered Persons in accordance with applicable federal and State privacy laws and rules including but not limited to 42 CFR §438.224, 42 CFR Part 431, Subpart F, 42 CFR Part 434 and 42 CFR 438.3 (if applicable), as may be amended from time to time. Access to member identifying information shall be limited by Provider to persons or agencies that require the information in order to perform their duties in accordance with this Agreement, including the U.S. Department of Health and Human Services (HHS), the Department and other individuals or entities as may be required. (See 42 CFR §431.300, et seq. and 45 CFR Parts 160 and 164.) Any other party shall be granted access to confidential information only after complying with the requirements of state and federal laws, including but not limited to HIPAA, and regulations pertaining to such access. Provider is responsible for knowing and understanding the confidentiality laws listed above as well as any other applicable laws. Nothing herein shall prohibit the disclosure of information in summary, statistical or other form that does not identify particular individuals, provided that deidentification of protected health information is performed in compliance with the HIPAA Privacy Rule. Federal and State Medicaid regulations, and some other federal and State laws and regulations, including but not limited to those listed above, are often more stringent than the HIPAA regulations. Provider shall notify Subcontractor, Health Plan and the Department of any breach of confidential information related to Covered Persons within the time period required by applicable federal and State laws and regulations following actual knowledge of a breach, including any use or disclosure of confidential information, any breach of unsecured PHI, and any Security Incident (as defined in HIPAA regulations) and provide Subcontractor, Health Plan and the Department with an investigation report within the time period required by applicable federal and State laws and regulations following the discovery. Provider shall work with Subcontractor, Health Plan and the Department to ensure that the breach has been mitigated and reporting requirements, if any, complied with.
10. Information. Provider shall release to Health Plan and/or Subcontractor any information necessary for Health Plan and/or Subcontractor to perform its obligations under the Centennial Care Contract.

11. 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.
12. Compliance with Law. Provider shall comply with all applicable State and federal statutes, rules and regulations, including but not limited to the following to the extent applicable to Provider in performance of the Agreement:
    a) 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.
    b) 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."
    c) 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 Department of Health and Human Services and the appropriate Regional Office of the Environmental Protection Agency.
    d) All applicable statutes, regulations and rules implemented by the Federal Government, the State of New Mexico, and HSD, concerning Medicaid services, managed care organizations ("MCOs"), health maintenance organizations, fiscal and fiduciary responsibilities applicable under the New Mexico Insurance Code of New Mexico, NMSA 1978, §§59A-1-1, et seq., and any other applicable statutes and regulations, and;
    e) All applicable regulations pertaining to the Coordinated Long-Term Services, NMAC Title 8, Chapter 306; other Long-Term Care Services, NMAC, Title 8, Chapter 315; Letters of Direction issued (and not otherwise rescinded) by HSD to the Centennial Care MCOs; and any suspension of contract requirements as may be issued by HSD.

    Moreover, Provider agrees and understands that a provider who furnishes services to a Medicaid eligible recipient agrees to comply with all federal and state laws, regulations, and executive orders relevant to the provision of services. Provider must conform to State program rules and instructions, appendices, program directions and billing instructions, as updated. Provider is also responsible for following coding manual guidelines and CMS correct coding initiatives, including not improperly unbundling or upcoding services. Provider must verify that individuals are eligible for a specific health care program administered by HSD and its authorized agents, and must verify the eligible recipient's enrollment status at the time services are furnished. Provider must determine if an eligible recipient has other health insurance. Provider must maintain records that are sufficient to fully disclose the extent and nature of the services provided to an eligible recipient.
13. Compliance with Medicaid Laws and Regulations. Provider agrees to abide by the Medicaid laws, regulations and program instructions to the extent applicable to Provider in Provider's performance of the Agreement. Provider understands that payment of a

claim by Subcontractor, Health Plan or the State is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited to, federal requirements on fraud, waste and abuse, disclosure, debarment, termination and exclusion screening), and is conditioned on the Provider's compliance with all applicable conditions of participation in Medicaid. Provider understands and agrees that each claim the Provider submits to Subcontractor and/or Health Plan constitutes a certification that the Provider has complied with all applicable Medicaid laws, regulations and program instructions in connection with such claims and the services provided therein. Provider's payment of a claim will be denied if Provider is terminated or excluded from participation in federal healthcare programs. Provider's payment of a claim may be temporarily suspended if the State, Subcontractor or Health Plan 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. Subcontractor and/or Health Plan 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 Subcontractor and/or Health Plan 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.

14. Encounter Data. If Provider is paying its own claims, within thirty (30) days after the end of each calendar month, Provider shall submit encounter data to Health Plan and/or Subcontractor, in lieu of claims, for Covered Services provided during that month. When submitting data electronically, Provider shall comply with federal standards for electronic transmission of data, security and privacy, including standards regarding encryption of data transmitted via the internet. 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 Subcontractor, Health Plan and State requirements. By submitting encounter data to Subcontractor and/or Health Plan, Provider represents to Subcontractor and/or Health Plan that the data is accurate, complete and truthful, and upon Subcontractor's and/or Health Plan's request Provider shall certify in writing, that the data is accurate, complete, and truthful, based on Provider's best knowledge, information and belief.
15. Excluded Individuals and Entities. By signing the Agreement, Provider certifies to the best of Provider's knowledge and belief that neither it nor any of its principals, nor any providers, agents, employees, subcontractors or consultants with whom Provider contracts and who are providing items or services that are significant and material to Provider's obligations under the Agreement is:
    a) excluded from participation in federal health care programs under either Section 1128 or section 1128A of the Social Security Act, or;
    b) debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order no. 12549 or under guidelines implementing Executive Order No. 12549; or an affiliate, as defined in the Federal Acquisition Regulation, of such a person.

    Provider is obligated to screen its employees and contractors to determine whether any of them have been excluded from participation in Medicare, Medicaid, CHIP, or any Federal Health Care Programs (as defined in Section 1128B(f) of the Social Security Act). Provider shall not employ or contract with an individual or entity that has been excluded. Provider shall immediately report to

Health Plan and/or Subcontractor any exclusion information discovered. Provider acknowledges and agrees that civil monetary penalties may be imposed against Provider if he or she employs or enters into contracts with excluded individuals or entities to provide items or Covered Services. Provider can search the HHS-OIG website, at no cost, by the names of any individuals or entities. The database is called LEIE and can be accessed at http://www.oig.hhs.gov/fraud/exclusions.asp. Health Plan and/or Subcontractor will exclude from its network any provider who has been excluded from the Medicare or Medicaid program in any state. Provider is also obligated to screen m o n t h l y all employees against, including those providing direct services to Covered Persons (e.g., home health, personal care), in accordance with the Employee Abuse Registry Act, NMSA 1978, § 27-7A-3, the New Mexico Caregivers Criminal History Screening Act, NMSA 1978, 29-17-2 et seq., and ensure that all employees are screened against the New Mexico "List of Excluded Individuals/Entities" and the Medicare exclusion databases. Provider shall further comply with 42 CFR § 438.08 regarding exclusion of entities, including all statutes and regulations referenced therein.

16. False Claims. If Provider receives annual Medicaid payments of at least Five million dollars ($5,000,000.00), or as otherwise required by the State, Provider shall comply with the following:
    a) Establish written policies for all employees, agents, or contractors; provide detailed information regarding the New Mexico Medicaid False Claims Act, NMSA 1978, §§27-14-1, et seq. and the Federal False Claims Act established under sections 3729 through 3733 of title 31, United States Code; administrative remedies for false claims and statements established under chapter 38 of Title 31, United States Code; and preventing and detecting fraud, waste, and abuse in federal health care programs (as defined in Section 1128B(f) of the Social Security Act);
    b) Include as part of such written policies detailed provisions regarding Provider's policies and procedures for detecting and preventing fraud, waste, and abuse, and;
    c) Include in any employee handbook a specific discussion of the laws described in 4.9(a), the rights of employees to be protected as whistleblowers, and Provider's policies for detecting and preventing fraud, waste, and abuse.
17. Hold Harmless. Provider agrees that in no event, including but not limited to nonpayment by Health Plan and/or Subcontractor, insolvency of Health Plan and/or Subcontractor, or breach of the Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against a Covered Person or a person (other than Health Plan and/or Subcontractor) acting on a Covered Person's behalf for services provided pursuant to the Centennial Care Contract, except for any Medicaid population required to make co-payments under HSD policy. In no event shall the State and/or any Covered Person be liable for any debts of Health Plan and/or Subcontractor. Provider shall hold harmless the State and Covered Persons in the event Health Plan and/or Subcontractor cannot or will not pay for services performed by Provider pursuant to an Agreement. This hold harmless provision shall survive termination of the Agreement for authorized services rendered prior to termination of the Agreement, regardless of the reason for the termination, and shall be construed for the benefit of Covered Persons. Pursuant to New Mexico Administrative Code 8.200.430.16, if the medical assistance services are not Covered Services, prior to providing the service, Provider shall inform the Covered Person of the non-covered service and have the Covered Person acknowledge the information. If the Covered Person still requests the service, Provider shall obtain such acknowledgement in writing prior to

rendering the service. If Health Plan and/or Subcontractor determines a Covered Person was charged for Covered Services inappropriately, such payment may be recovered, as applicable. This provision shall survive any termination of the Agreement, including breach of the Agreement due to insolvency.

18. Indemnification. To the extent applicable to Provider in performance of the Agreement, Provider shall indemnify, defend and hold HSD and Collaborative and its employees harmless from and against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses, including court costs and attorney fees, to the extent proximately caused by any negligent act or other intentional misconduct or omission of Provider, its agents, officers, employees or contractors arising from the Agreement. HSD and Collaborative may waive this requirement for public entities if Provider is a state agency or sub-unit as defined by the State or a public health entity with statutory immunity. This clause shall survive the termination of the Agreement for any reason, including breach due to insolvency.
19. Cultural Competency and Access. Provider shall participate in Health Plan's, Subcontractor's and the State's efforts to promote the delivery of services in a culturally competent manner to all Covered Persons, including those with limited English proficiency, physical or mental disabilities, diverse cultural and ethnic backgrounds, and regardless of gender, sexual orientation or gender identity, and shall provide interpreter services in a Covered Person's primary language and for the hearing impaired for all appointments and emergency services. Provider shall provide information to Covered Persons regarding treatment options and alternatives, as well as information on complaints and appeals, in a manner appropriate to the Covered Person's condition and ability to understand. Provider shall provide physical access, reasonable accommodations, and accessible equipment for Covered Persons with physical or mental disabilities.
20. Employee Health Coverage Requirements. If Provider has or anticipates having six (6) or more employees who reside in New Mexico and who work, or who worked, are working or are expected to work, an average of at least twenty (20) hours per week over a six (6) month period with said six-month period beginning at any time during the year prior to entering into the Agreement or at anytime during the term of the Agreement, Provider certifies by signing the Agreement to:
    a) Have in place and agree to maintain for the term of the Agreement, health insurance for those New Mexico employees and offer that health insurance to those employees no later than July 1, 2008 if the expected annual value in the aggregate of the Agreement and any contracts between Provider and the State exceeds One million dollars ($1,000,000.00), or;
    b) Have in place and agree to maintain for the term of the Agreement, health insurance for those New Mexico employees and offer that health insurance to those employees no later than July 1, 2009 if the expected annual value in the aggregate of the Agreement and any contracts between Provider and the State exceeds Five hundred thousand dollars ($500,000.00), or;
    c) Have in place and agree to maintain for the term of the Agreement, health insurance for those New Mexico employees and offer that health insurance to those employees no later than July 1, 2010 if the expected annual value in the aggregate of the Agreement and any contracts between Provider and the State exceeds Two hundred fifty thousand dollars ($250,000.00).
    d) Provider agrees to maintain a record of the number of employees who have:
        i. Accepted health insurance;
        ii. Declined health insurance due to other health insurance coverage already in place, or;

iii. Declined health insurance for other reasons. Such records are subject to review and audit by the State or its representative.

e) Provider further agrees to advise all New Mexico employees in writing of the availability of State publicly financed health coverage programs by providing each employee with, at a minimum, the following web site link for additional information http://insurenewmexico.state.nm.us/.

f) Failure to comply with the requirements of this section may result in immediate termination of the Agreement, or as may be mandated by the State.

21. Marketing. As required under the Centennial Care Contract, any marketing materials developed and distributed by Provider as related to performance of the Agreement must be submitted to Health Plan and/or Subcontractor to submit to the Centennial Care Program for prior approval. Provider agrees not to engage in the following marketing and outreach activities, which are prohibited under the Centennial Care Contract:
    a) Asserting or implying that a Covered Person shall lose Medicaid benefits if he/she does not enroll with Health Plan and/or Subcontractor or inaccurately depicting the consequences of choosing a different managed care organization;
    b) Designing a marketing or outreach plan that discourages or encourages selection of a managed care organization based on health status or risk;
    c) Initiating an enrollment request on behalf of a Centennial Care recipient;
    d) Making inaccurate, false, materially misleading or exaggerated statements;
    e) Asserting or implying that Health Plan and/or Subcontractor offers unique covered services when another managed care organization provides the same or similar service;
    f) Using gifts or other incentives to entice people to join a specific health plan;
    g) Directly or indirectly conducting door-to-door, telephonic or other “cold call” marketing. “Cold call” marketing means any unsolicited personal contact by Health Plan and/or Subcontractor, either directly or through subcontractors or providers, with a potential Covered Person for the purpose of marketing. Marketing includes any communication from Health Plan and/or Subcontractor or Provider to an individual who is not enrolled with Health Plan and/or Subcontractor that can reasonably be interpreted as intended to influence the individual to enroll in Health Plan’s and/or Subcontractor’s Centennial Care product and not to enroll in, or to disenroll, from another managed care organization’s Centennial Care product;
    h) Conducting any other marketing activity prohibited by the State during the course of the Agreement;
    i) Including statements that Provider is endorsed by CMS, the federal or state government, or a similar entity, and;
    j) Provider shall comply with all federal rules regarding Medicare – Medicaid Marketing (Chapter 42 of the CFR, Parts 422 and 423) and the CMS Medicare – Medicaid Marketing Guidelines found at: https://www.cms.gov/ManagedCareMarketing/03_FinalPartCMarketingGuidelines.asp.
22. Services. Provider shall perform those services set forth in the Agreement, which shall also describe how the services performed by Provider are accessed by Covered Persons.
23. 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 Health Plan and/or Subcontractor has delegated credentialing to Provider, Health Plan and/or Subcontractor will provide monitoring and oversight and Provider shall ensure all licensed medical

professionals are credentialed in accordance with Health Plan's and/or Subcontractor's and the Centennial Care Contract's credentialing requirements. Indian Health Service (IHS) health care professionals employed by an Indian tribe or tribally operated health program are exempt from the state licensing requirements of the state in which the tribe or organization performs services, if the health care professional is licensed in any state or its territories, pursuant to the Indian Health Care Improvement Act (IHCIA).

24. Lobbying. Provider certifies in accordance with the Byrd Anti-Lobbying Amendment, to the best of its knowledge and belief that:
    a) No federally appropriated funds have been paid or will be paid, by or on behalf of Provider, 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 awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.
    b) If any funds other than federally appropriated funds have been paid or shall be paid to any person for 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 Agreement or Centennial Care Contract, Provider shall complete and submit Standard Form-LLL "Disclosure Form to Report Lobbying" in accordance with its instructions.
25. Fraud, Waste and Abuse Prevention. Provider shall cooperate fully with Health Plan's and/or Subcontractor'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 Centennial Care Contract. Provider shall cooperate and assist the Centennial Care Program 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 federal health care programs. This shall include, but not be limited to, cooperating fully in any investigation by the New Mexico State Medicaid Fraud Control Unit of the Attorney General's Office ("MFCU") or subsequent legal action that may result from such investigation. Provider shall, upon request, make available to MFCU any and all administrative, financial and medical records relating to delivery of items or services for which State monies are expended, unless otherwise provided by law. In addition, MFCU shall be allowed to have access during normal business hours to the place of business and all records of Provider, except under special circumstances when after hours access shall be allowed. Special circumstances shall be determined by MFCU. Provider also agrees to cooperate with the retrospective claim review activities of the Medicaid Recovery Audit Contractor (RAC), complying with all requirements and expectations set forth in Section 6411 of the Affordable Care Act, Expansion of the Recovery Audit Contractor Program, and in accordance with guidance from CMS and State rules. In accordance with Health Plan's and/or Subcontractor's policies and the Deficit Reduction Act of 2005 (DRA), Provider shall have written policies for its employees, contractors or agents that: (a) provide detailed information about the federal False Claims Act (established under sections 3729 through 3733 of title 31, United States Code), including, if any entity makes or receives annual payments under the State Program of at least $5,000,000, such entity must establish certain minimum written policies and information communicated through an employee handbook relating to the Federal False Claims Act in accordance with 42 CFR §438.600; (b) cite administrative remedies for false claims and statements (established under chapter 38 of title 31, United

States Code) and whistleblower protections under federal and state laws; (c) reference state laws pertaining to civil or criminal penalties for false claims and statements; and (d) with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in federal health care programs (as defined in section 1128B(f)), include as part of such written policies, detailed provisions regarding Provider's policies and procedures for detecting and preventing fraud, waste, and abuse. Provider agrees to train its staff on the aforesaid policies and procedures. 3.27 Data; Reports. Provider shall cooperate with and release to Health Plan and/or Subcontractor any information necessary for Health Plan and/or Subcontractor to perform its obligations under the Centennial Care Contract to the extent applicable to Provider in performance of the Agreement, including the timely submission of reports and information required by Health Plan and/or Subcontractor, in the format specified by Health Plan, Subcontractor or the State. Such reports shall include child health check-up reporting, if applicable, as well as complete and accurate encounter data in accordance with the requirements of Health Plan, Subcontractor, and the State. Data must be provided at the frequency and level of detail specified by Subcontractor, Health Plan or the State. By submitting data to Subcontractor and/or Health Plan, Provider represents and attests to Subcontractor, Health Plan and the State that the data is accurate, complete and truthful, and upon Subcontractor's and/or Health Plan's request Provider shall certify in writing, that the data is accurate, complete, and truthful, based on Provider's best knowledge, information and belief.

26. Insurance Requirements. As applicable, Provider shall secure and maintain during the term of the Agreement insurance appropriate to the services to be performed under the Agreement.
27. Physician Incentive Plans. In the event Provider participates in a physician incentive plans ("PIP") under the Agreement, Provider acknowledges and agrees that such PIP must comply with 42 CFR 417.479, 42 CFR 438.3(i), 42 CFR 438.6(h), 42 CFR 422.208 and 42 CFR 422.210, as may be amended from time to time. Neither Health Plan, Subcontractor, 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 Services. Direct or indirect incentives must not serve as an inducement to reduce or limit Medically Necessary Services furnished to Covered Persons.
28. Disclosure. Provider shall cooperate with Health Plan and Subcontractor in disclosing information the State may require related to ownership and control, significant business transactions, and persons convicted of crimes in accordance with 42 C.F.R. §§ 455.104, 455.105, and 455.106. Provider must be screened and enrolled into the State's Medicaid or CHIP program, as applicable, and submit disclosures to the State or HSD on ownership and control, significant business transactions, and persons convicted of crimes, including any required criminal background checks, in accordance with 42 CFR Part 455 Subparts B and E. Provider must submit information related to ownership and control of subcontractors or wholly owned suppliers within thirty-five (35) calendar days of a request for such information in accordance with 42 CFR 455.105. Additionally, Provider must cooperate with the State or HSD for submission of fingerprints upon a request from the State, HSD or CMS in accordance with 42 CFR 455.434.
29. Health Care Acquired/Preventable Conditions. Provider agrees that no payment shall be made for the provision of medical assistance for health care acquired conditions and other provider preventable conditions as may be identified by the State. As a condition of payment, Provider shall identify and report to Health Plan and Subcontractor any provider preventable conditions in accordance with 42 CFR §§ 434.6(a) (12), 438, including but not limited to § 438.3g, and § 447.26.

30. Quality; Utilization Management. Pursuant to any applicable provider manuals and related protocols, or as elsewhere specified under the Agreement, Provider agrees to cooperate with Health Plan's and Subcontractor's quality assessment, performance improvement and utilization review and management activities. 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 Health Plan and Subcontractor or as required under the Centennial Care Contract to ensure that Covered Persons have due process for their complaints, grievances, appeals, fair hearings or requests for external review of adverse decisions made by Health Plan and/or Subcontractor or Provider. Provider shall adhere to the quality assurance and utilization review standards of the applicable Centennial Care Program and shall monitor quality and initiate corrective action to improve quality consistent with the generally accepted level of care. Furthermore, Provider agrees to participate and cooperate in any internal and external QM/QI monitoring, utilization review, peer review and/or Appeal procedures established by Health Plan, Subcontractor, and/or State.
31. Conflict of Interest. Provider shall cooperate with Health Plan's and Subcontractor's policies and procedures related to detection and preventing conflicts of interest at all levels. Moreover, Providers shall comply with, all applicable provisions of the New Mexico Government Conduct Act, Chapter 10, Article 16 NMSA 1978.
32. National Provider ID (NPI). If applicable, Provider shall obtain a National Provider Identification Number (NPI).
33. Payment in Full. Provider shall accept payment or appropriate denial made by Health Plan and/or Subcontractor, as applicable, (or, if applicable, payment by Health Plan and/or Subcontractor that is supplementary to the Covered Person's third party payer) plus the amount of any applicable Customer cost sharing responsibilities, as payment in full for Covered Services provided and shall not solicit or accept any surety or guarantee of payment from the Customer in excess of the amount of applicable cost sharing responsibilities.
34. Behavioral Health Planning. Provider shall participate in disaster Behavioral Health planning efforts at their local area level.
35. Covered Person Rights:
    a) Provider shall ensure that each Covered Person is free to exercise his or her rights and that the exercise of these rights does not adversely affect the way Provider treats the Covered Person.
    b) Provider shall have written policies regarding the Covered Person's, and/or Representatives' rights including, but not limited to, the guaranteed right to:
        i. Be treated with respect and with due consideration for his or her dignity and privacy;
        ii. Receive information on available treatment options and alternatives, presented in a manner appropriate to the his or her condition and ability to understand;
        iii. Make and have honored an Advance Directive consistent with State and federal laws;
        iv. Receive Covered Services in a nondiscriminatory fashion;
        v. Participate in decisions regarding his or her health care, including the right to refuse treatment;
        vi. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation;
        vii. Request and receive a copy of his or her medical records and to request that they be amended or corrected as specified in 45 C.F.R. Part 164;

viii. Choose a Representative to be involved as appropriate in making care decisions;
ix. Provide informed consent;
x. Voice Grievances about the care provided by the Health Plan and/or Subcontractor and to make use of the Grievance, Appeal and Fair Hearing processes without fear of retaliation;
xi. Choose from Providers in accordance with Health Plan's and Subcontractor's prior authorization requirements;
xii. Receive information about Covered Services and how to access Covered Services, and Providers;
xiii. Be free from harassment by the Providers in regard to contractual disputes between Health Plan, Subcontractor, and Providers, and;
xiv. Participate in understanding physical and Behavioral Health problems and developing mutually agreed-upon treatment goals.

c) Provider shall ensure that each Covered Person (and/or as appropriate, Representative) is free to exercise his or her rights and that the exercise of those rights does not adversely affect the way the way Providers treat the Covered Person (and/or Representative).

36. Cost Sharing and Patient Liability. Provider agrees to comply with all responsibilities and prohibited activities regarding cost sharing and patient liability as provided in the Centennial Care Contract, including, but not limited to, the following:
    a) Provider shall impose the maximal nominal copayments for non-emergency use of the emergency room in accordance with federal regulations for individuals over 100% of the federal poverty level. Provider may not deny services for a Covered Person's failure to pay the copayment amount. Provider shall not impose any copayments on Native Americans. Provider shall not reduce payments to hospitals or emergency rooms for any Covered Person non-emergent visits to the emergency room.
    b) Provider shall impose the maximal nominal copayment in accordance with federal regulations for individuals over 100% of the federal poverty level on any prescription filled for a Covered Person with a legend drug when a therapeutically equivalent generic drug is available. This copayment shall not apply to legend drugs that are classified as psychotropic drugs for the treatment of Behavioral Health conditions. Provider shall develop a copayment exception process to be prior approved by State for other legend drugs where such drugs are not tolerated by the Covered Person. Provider may not deny services for a Covered Person's failure to pay the copayment amounts. Provider shall not impose any copayments on Native Americans.
    c) Provider shall have policies and procedures to ensure that, where applicable, Covered Persons residing in residential facilities pay their patient liability. State will notify Provider of any applicable patient liability amounts for Covered Persons via the eligibility/enrollment file. Provider shall delegate collection of patient liability to the Nursing Facility or community-based residential alternative facility and shall pay the facility net of the applicable patient liability amount. Provider shall submit patient liability information associated with Claim payments to providers in its Encounter Data submission.
37. Prohibition of Bribes, Gratuities and Kickbacks. Pursuant to the State of New Mexico statutes and regulations, Provider shall not accept or solicit bribes, gratuities and kickbacks. No elected or appointed officer or other employee of the State of New Mexico shall benefit financially or materially from this Agreement. No individual employed by the

State of New Mexico shall be admitted to any share or part of the Agreement or to any benefit that may arise there from.

38. Notice. Provider shall display notices of the Covered Person's right to Appeal adverse action affecting services in public areas of Provider's facility(s) in accordance with HSD rules and regulations, subsequent amendments.
39. Care Coordination. If applicable, Provider must notify the care coordinator of any change in a Covered Person's medical or functional condition that could impact the Covered Person's level of care determination.
40. Overpayments. Provider shall comply with the following:
    a) Provider is required to report overpayments to Health Plan by the later of:
        i. the date which is sixty (60) calendar days after the date on which the overpayment was identified; or
        ii. the date any corresponding cost report is due, if applicable.

    A person has identified an overpayment if the person has actual knowledge of the existence of an overpayment or acts in reckless disregard or with deliberate indifference of the overpayment.

    An overpayment shall be deemed to have been "identified" when:
        i. Provider reviews billing or payment records and learns that it incorrectly coded certain services, resulting in increased reimbursement;
        ii. A Provider learns that a patient death occurred prior to the service date on which a claim that has been submitted for payment;
        iii. A Provider learns that services were provided by unlicensed or excluded individual on its behalf;
        iv. A Provider performs an internal audit and discovers that an overpayment exists;
        v. A Provider is informed by a government agency of an audit that discovered a potential overpayment;
        vi. A Provider is informed by Health Plan of an audit that discovered a potential overpayment;
        vii. A Provider experiences a significant increase in Medicaid revenue and there is no apparent reason – such as a new partner added to a group practice or new focus on a particular area of medicine – for the increase;
        viii. A Provider has been notified that Subcontractor, Health Plan or a government agency has received a hotline call for email, and;
        ix. A Provider has been notified that Subcontractor, Health Plan, or a government agency has received information alleging that a recipient had not received services or been supplied goods for which the Provider submitted a claim for payment.
    b) Within sixty (60) calendar days from the date on which the Provider identifies an overpayment, Provider shall send an "Overpayment Report" to Health Plan and HSD which shall include:
        i. Provider's name;
        ii. Provider's tax identification number and National Provider Number;
        iii. How the overpayment was discovered; (iv) The reason for the overpayment;
        iv. The health insurance claim number, as appropriate; (vi) Date(s) of service;
        v. Medicaid claim control number, as appropriate;
        vi. Description of a corrective action plan to ensure the overpayment does not occur again;

vii. Whether the Provider has a corporate integrity agreement (CIA) with the United States Health and Human Services Department Office of Inspector General (OIG) or is under the OIG Self-Disclosure Protocol;
viii. The specific dates (or time-span) within which the problem existed that cause the overpayments;
ix. If a statistical sample was used to determine the overpayment amount, a description of the statistically valid methodology used to determine the overpayment, and;
x. The refund amount.

c) Provider shall pay all self-reported refunds for overpayments to Health Plan as an intermediary and are property of Health Plan unless HSD, the RAC or MFEAD independently notified the Provider that an overpayment existed. The Provider may:
   i. request that Health Plan permit installment payments of the Refund, such request be agreed to by Health Plan and the Provider, or;
   ii. in cases where HSD, the RAC, or MFEAD identify the overpayment, HSD shall seek recovery of the overpayment in accordance with NMAC §8.351.2.13.

d) Provider acknowledges that overpayments that have been identified by the Provider and not self-reported within the sixty (60)-day timeframe are presumed to be false claims and are subject to referrals as credible allegations of fraud.

41. Electronic Visit Verification (EVV). Provider shall cooperate with State requirements for electronic visit verification for personal care services and home health services, as applicable.
42. Non-Discrimination Against Covered Persons. Provider will not discriminate against Covered Persons on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability and will not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin, sex, sexual orientation gender identity, or disability.
43. Transition of Covered Persons. In the event of transitioning Covered Persons from other Medicaid managed care contractors and their provider, Provider shall work with Subcontractor and Health Plan to ensure quality-driven health outcomes for such Covered Persons to the extent required by the State Contract or otherwise required by law.
44. Continuity of Care. Provider shall cooperate with Subcontractor and Health Plan and provide Covered Persons with continuity of treatment, including coordination of care to the extent required under law and according to the terms of the Agreement, in the event Provider's participation with Health Plan terminates during the course of a Covered Person's treatment by Provider, except in the case of adverse reasons on the part of Provider.
45. Health Records. Provider agrees to cooperate with Subcontractor and/or Health Plan to maintain and share a health record of all services provided to a Covered Person, as appropriate and in accordance with applicable laws, regulations and professional standards.
46. Advance Directives. When applicable, Provider shall comply with the advance directives requirements for hospitals, nursing facilities, providers of home and health care and personal care services, hospices, and HMOs as specified in 42 CFR Part 49, subpart I, 42 CFR § 417.436(d), 42 CFR § 422.128, and 42 CFR 438.3(i).
47. Termination. In the event of termination of the Agreement, Provider shall promptly supply to Subcontractor and/or Health Plan all information necessary for the reimbursement of any outstanding Medicaid claims.

IV. Additional Provider Requirements for Specific Activities.

1. Pharmacy Providers. Payment for pharmacy providers shall be consistent with NMSA 1978, § 27-2-16B unless there is a change in statute or regulation;
2. Laboratory Providers. Laboratory service providers shall meet all applicable requirements of the Clinical Laboratory Improvement Amendments (CLIA) of 1988;
3. Nursing Facility Requirements. Provider shall:
    a) promptly notify Health Plan and Subcontractor of (i) a Covered Person's admission or request for admission to the Nursing Facility regardless of payor source for the Nursing Facility stay, (ii) a change in a Covered Person's known circumstances and (iii) a Covered Person's pending discharge;
    b) notify the Covered Person and/or the Covered Person's Representative in writing prior to discharge in accordance with State and federal requirements.
4. Agency-Based Community Benefit Provider. Provider shall provide at least thirty (30) Calendar Days advance notice to Health Plan and Subcontractor when Provider is no longer willing or able to provide services to a Covered Person, including the reason for the decision, and to cooperate with the Covered Person's care coordinator to facilitate a seamless transition to alternate providers.
   Reimbursement of Provider shall be contingent upon the provision of services to an eligible Covered Person in accordance with applicable federal and State requirements and the Covered Person's care plan as authorized by Health Plan and/or Subcontractor.
   Additionally, Provider shall immediately report any deviations from a Covered Person's service schedule to Health Plan and/or Subcontractor.
5. Home and Community Based (HCB) Providers. HCB Providers shall comply with all applicable federal requirements for HCB settings requirements including, but not limited to, 42 CFR § 441.301(c)(4).
6. Mental Health and Substance Use Providers. Providers who provide Mental Health and Substance Use services to Covered Persons must provide for services to be delivered in compliance with the requirements of 42 CFR 438.3 subpart K insofar as those requirements are applicable.

V. Health Plan and/or Subcontractor's Obligation.
1. Delegated Activities. Any activities delegated to Provider by Health Plan and/or Subcontractor shall be set forth in the Agreement or such other written delegation agreement between the parties. The Agreement or delegation agreement shall specify the activities and reporting responsibilities delegated to Provider and provide for revoking delegation or imposing other sanctions if Provider's performance is inadequate.
2. Termination, Revocation, and Sanctions. In addition to Health Plan's and Subcontractor's termination rights under the Agreement, Health Plan and Subcontractor may terminate, rescind or cancel the Agreement in the event Provider violates any applicable HSD or Collaborative requirements or State or federal statutes, rules or regulations. Health Plan and Subcontractor also have the right to revoke any functions or activities delegated to Provider or impose other sanctions consistent with the Centennial Care Contract if in Health Plan's and/or Subcontractor's reasonable judgment Provider's performance under the Agreement is inadequate. Health Plan and Subcontractor shall also have the right to suspend, deny, refuse to renew or terminate Provider in accordance with the terms of the Centennial Care Contract and applicable law and regulation. Additionally, any program violations arising out of performance of the Agreement are subject to administrative enforcement by the Health and Human Services Commission Office of Inspector General (OIG). Health Plan shall notify HSD within 5 business days, via e-mail, when a formal written action is taken by Health against a provider. Such action being defined for purposes of this provision as: (i) denial of credentialing or enrollment, or contract termination, when the denial or termination is "for cause", as such term is

defined in the provider's agreement with Health Plan; or (ii) due to concerns other than fraud, such as integrity or quality.

3. Prompt Payment. Health Plan and/or Subcontractor, as applicable, shall pay Provider pursuant to the Centennial Care Contract, applicable State law and regulations, and 42 CFR 447.46, 42 CFR 447.45(d)(2), 42 CFR 447.45(d)(3), 42 CFR 447.45(d)(5) and 42 CFR 447.45(d)(6), as applicable and as may be amended from time to time. In regard to Centennial Care Contract obligations, Subcontractor will pay Provider upon approval of a clean claim properly submitted by the Provider within the required time frames (See Section 4.19.1.6 of the Centennial Care Contract.). If Provider is an Indian Health Service (IHS) or Tribal 638 provider, reimbursement will follow federal and State regulations for Covered Services provided to Covered Persons entitled to receive Covered Services through Indian Health Services (IHS) and Tribal 638 providers. 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 Centennial Care Contract. Unless Health Plan and/or Subcontractor otherwise requests assistance from Provider, Health Plan and/or Subcontractor will be responsible for third party collections in accordance with the terms of the Centennial Care Contract.
4. Communication with Covered Persons. Health Plan and/or Subcontractor shall not:
    a) prohibit or restrict Provider from assisting or advocating on behalf of a Covered Person in any appeals and grievance process or otherwise acting to protect a Covered Person's interests;
    b) prohibit or otherwise restrict Provider from advising Covered Persons about their health status or medical care or treatment as provided in Section 1932(b)(3) of the Social Security Act, 42 CFR § 438.102 or in contravention of the New Mexico Patient Protection Act, NMSA 1978, §59A-57-1 to 57-11, as may be amended from time to time;
    c) prohibit 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, or;
    d) sanction Provider for any actions described above.
5. No Incentives to Limit Medically Necessary Services. Health Plan and/or Subcontractor shall not structure compensation provided to individuals or entities that conduct utilization management and concurrent review activities so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary services to any Covered Person.
6. Non-Discrimination Against Providers. Health Plan and Subcontractor shall not discriminate with respect to participation, reimbursement, or indemnification of Provider when acting within the scope of Provider's license or certification under applicable State law, solely on the basis of such license or certification. This provision does not prohibit Health Plan and Subcontractor from limiting 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 Health Plan and Subcontractor that are designed to maintain quality of care practice standards and control costs. Pursuant to section 1932(b)(7) of the Social Security Act, and consistent with 42 CFR 438.12, Health Plan and Subcontractor also shall not discriminate against Provider for serving high-risk Covered Persons or if Provider specializes in conditions requiring costly treatments.
7. Grievance System. Health Plan and/or Subcontractor shall provide Provider information specified in 42 CFR 438.10(g)(2)(xi) about Health Plan's and/or Subcontractor's grievance system at the time Health Plan, Subcontractor, and Provider enter into the Agreement.

VI. Other Requirements.

1. Compliance with the Centennial Care Contract. All tasks performed under the Agreement shall be performed in accordance with the requirements of the Centennial Care Contract, as set forth in this Appendix, applicable manuals and protocols, policies and procedures that Health Plan and Subcontractor have provided or made available to Provider. The applicable provisions of the Centennial Care Contract are incorporated into the Agreement by reference. Nothing in the Agreement or this Appendix relieves Health Plan and/or Subcontractor of their responsibility under the Centennial Care Contract. If any provision of the Agreement or this Appendix is in conflict with provisions of the Centennial Care Contract, the terms of the Centennial Care Contract shall control and the terms of the Agreement or this Appendix in conflict with those of the Centennial Care Contract will be considered waived. Provider acknowledges that in order to meet the Centennial Care contract requirements, Health Plan and/or Subcontractor may offset overpayments against future payments when notifying Provider of the same.
2. State Approval. Health Plan, Subcontractor, and Provider acknowledge that the State reserves the right to review and disapprove the Agreement and/or any significant subsequent modifications to the Agreement.
3. Monitoring. Health Plan and/or Subcontractor shall perform ongoing monitoring (announced or unannounced) of services rendered by Provider under the Agreement and shall perform periodic formal reviews of Provider according to a schedule established by the State, consistent with industry standards or State managed care organization laws and regulations or requirements under the Centennial Care Contract. As a result of such monitoring activities, Health Plan and/or Subcontractor shall identify to Provider any deficiencies or areas for improvement mandated under the Centennial Care Contract and Provider and Health Plan and/or Subcontractor shall take appropriate corrective action. Provider shall comply with any corrective action plan initiated by Health Plan and/or Subcontractor, and/or required by the Centennial Care Program action to improve quality of care, in accordance with that level of medical, behavioral health or long-term care that is recognized as acceptable professional practices and/or the standards established by State. In addition, Provider shall monitor and report the quality of services delivered under the Agreement and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which Health Plan and/or Subcontractor, and Provider practice and/or the performance standards established under the Centennial Care Contract.
4. Reimbursement Rates. The reimbursement rates for Provider's performance of services under the Agreement and any risk assumption, if applicable, shall be as set forth in the Agreement. Provider shall comply with all requirements of the Fair and Equal Pay for All New Mexicans as set forth in Executive Order 2009-049 or any other applicable fair and equal pay law.
5. No Restrictions on Other Contracts. Nothing in the Agreement or this Appendix shall be construed to prohibit or restrict Provider from entering into a contract with another managed care organization. Health Plan and/or Subcontractor shall not provide incentives or disincentives to Provider that discourage Provider from entering into a contractual relationship with another managed care organization.
6. Regulatory Amendment. Subcontractor may amend this Appendix to comply with the requirements of State and federal regulatory authorities and shall give written notice to Provider of such amendment and its effective date. Unless such regulatory authorities direct otherwise, the signature of Provider will not be required.
7. Termination of Agreement by State. The State reserves the right to direct Health Plan and/or Subcontractor to terminate or modify the Agreement when the State determines it to be in the best interest of the State. Provider recognizes that in the event of

termination of the Agreement, Provider shall immediately make available, to State or its designated representative in a usable form any or all records whether medical or financial related to the Provider's activities undertaken pursuant to the Agreement. The provision of such records shall be at no expense to State.

8. Provider Relationship. Provider is not a third party beneficiary to the Centennial Care Contract and that Provider is an independent contractor performing services as outlined in the Centennial Care Contract.
9. Operation in New Mexico. Health Plan, Subcontractor, and Provider represent and warrant that they have a legal basis for operating in the State of New Mexico.