MASSACHUSETTS GOVERNMENT PROGRAMS

REGULATORY REQUIREMENTS APPENDIX

DOWNSTREAM PROVIDER

THIS MASSACHUSETTS GOVERNMENT PROGRAMS REGULATORY REQUIREMENTS APPENDIX (this "Appendix") supplements and is made part of the provider agreement (the "Agreement") between UnitedHealthcare Insurance Company or one of its Affiliates (collectively, "United") and the party named in the Agreement ("Provider").

SECTION 1
APPLICABILITY

This Appendix applies with respect to the provision of health care services Provider provides directly to Members under the Massachusetts Medicaid, One Care or MassHealth Senior Care Options (each, a "State Program" and collectively, the "State Programs") as governed by the State's designated regulatory agencies. This Appendix also applies to the Medicare program for Dual Eligible Members (as defined below). In the event of a conflict between this Appendix and other appendices or any provision of the Agreement, the provisions of this Appendix shall control except with regard to benefit plans outside the scope of this Appendix or unless otherwise required by law.

SECTION 2
DEFINITIONS

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

2.1 Centralized Enrollee Record: A centralized and comprehensive record documenting each Covered Person's medical, functional, and social status, and containing information relevant to maintaining and promoting each Covered Person's general health and well being, as well as clinical information concerning illnesses and chronic medical conditions.

2.2 Covered Service means health care service or product for which a Member is enrolled with United to receive coverage under the State Program.

2.3 Medicaid Agency or Agency means the single State agency of administering or supervising the administration of the State Program.

2.4 State is the State of Massachusetts.

2.5 State Contract is the contract between United and the Medicaid Agency for the purpose of providing and paying for Covered Services to Members enrolled in the State Program.

SECTION 3
PROVIDER REQUIREMENTS

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

3.1 Definitions Related to the Provision of Covered Services. Provider shall follow the applicable State Program's requirements for the provision of Covered Services. Provider's decisions affecting the delivery of acute or chronic care services to Members shall be made on an individualized basis and in accordance with the following definitions:

i) **Emergency Medical Condition or Emergency Condition:** In accordance with 42 CFR § 438.114 (a) and 42 CFR § 422.113(b)(i), Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: (a) 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; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part.

ii) **Emergency Services:** In accordance with 42 CFR § 438.114 (a) and 42 CFR § 422.113(b)(ii), Emergency Services means inpatient and outpatient Covered Services furnished by a provider qualified to furnish those health services and that are needed to evaluate or stabilize an Emergency Medical Condition.

iii) **Medically Necessary or Medical Necessity** has the same meaning as contained in 42 C.F.R. § 438.210(a)(5) and as indicated in State statutes and regulations, the State Contract, and other State policy and procedures.

iv) **Poststabilization Care Services** means covered services, related to an emergency medical condition that are provided after a Member is stabilized to maintain the stabilized condition, or, under circumstances described in condition that are provided after a Member is stabilized to maintain the stabilized condition, or, under the circumstances described in 42 C.F.R. § 422.113(c), to improve or resolve the Member's condition.

v) **Urgent Care** means medical services required promptly to prevent impairment of health due to symptoms that do not constitute an Emergency Condition, but that are the result of an unforeseen illness, injury, or condition for which medical services are immediately required. Urgent Care is appropriately provided in a clinic, physician's office, or in a hospital emergency department if a clinic or physician's office is inaccessible. Urgent Care does not include Primary Care services or services provided to treat an Emergency Condition.

3.2 Provider Participation Requirements. Provider hereby acknowledges and certifies to the best of its knowledge the following:

i) State Program Participation. Provider is enrolled as, or has applied to enroll as, a participating provider with the State Program. United may terminate Provider from its State Program Provider network immediately upon notification from the State that

Provider cannot be enrolled or has been terminated from the State Program, or the expiration of one 120 day period without enrollment of Provider.

ii) **Licensure.** Provider has all necessary licenses, certifications, registrations and permits as are required to provide the health care services and/or other related activities delegated to Provider by United under the Agreement and will maintain such necessary licenses, certifications, registrations and permits at all times throughout the term of the Agreement. If at any time during the term of the Agreement, Provider is not in compliance with this Section, Provider shall discontinue providing services to Member. Additionally, payment will not be made for any items or Covered Services provided during any time period of noncompliance with this Section.

iii) **Excluded Individuals and Entities**. Provider nor any of its employees, principals, nor any providers, subcontractors or consultants or persons with an ownership or controlling interest in the Provider are: (a) debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549; or b) excluded from participation in federal health care programs under either 42 U.S.C. §§ 1320a–7 or 1320a–7a. Provider acknowledges and agrees that payment will not be made for any items or Covered Services provided by an excluded individual or entity pursuant to 42 C.F.R. § 1001.1901(b).

3.3 Compliance with Law. Provider shall comply with all federal and State laws and regulations applicable to Provider in performance of the Agreement, including but not limited to, the following:

i) **Civil Rights.** Provider shall comply with Title VI of the Civil Rights Act of 1964; the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; Title IX of the Education Amendments of 1972; Titles II and III of the Americans with Disabilities Act; and section 1557 of the Patient Protection and Affordable Care Act (see 42 CFR 438.3; 42 CFR 438.100(d)).

ii) **Lobbying.** Provider certifies to the best of Provider's knowledge and belief, pursuant to 31 U.S.C. § 1352 and 45 C.F.R. § 93.100 et seq. that no federally appropriated funds have been paid or will be paid to any person by or on Provider's behalf for the purpose of influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

iii) **Medicaid Laws and Regulations.** Provider agrees to abide by all federal and state Medicaid laws, regulations and State Program requirements, including but not limited to:

a. 5 C.F.R. § 900.601 et seq., Administration of the Standards for a Merit System of Personnel Administration.

b. The following HHS Regulations in 45 C.F.R. subtitle A:

i. 45 C.F.R. § 16.1 et seq., Procedures of the Departmental Appeals Board;

ii. 45 C.F.R. § 75.1 et seq., Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards;

iii. 45 C.F.R. § 80.1 et seq., Nondiscrimination Under Programs Receiving Federal Assistance Through the Department of Health and Human Services: Effectuation of Title VI of the Civil Rights Act of 1964;

iv. 45 C.F.R. § 81.1 et seq., Practice and Procedure for Hearings Under 45 C.F.R. § 80.1 et seq.;

v. 45 C.F.R. § 84.1 et seq., Nondiscrimination on the Basis of Handicap in Programs and Activities Receiving or Benefiting from Federal Financial Assistance.

c. **Availability of Services.** Provider will comply with 42 C.F.R. § 438.206 and any applicable State Program regulations and requirements related to availability of services to Member including, but not limited to, meeting State Program standards for timely access to care and services, taking into account the urgency of the need for services. Additionally, Provider shall offer hours of operation that are no less than the hours of operation offered to commercial beneficiaries or comparable to Medicaid fee-for-service beneficiaries, 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. In addition, Provider will provide physical access, reasonable accommodations and accessible equipment for Member's with physical or mental disabilities.

d. **Claims Information.** Provider shall promptly submit to United the information needed to make payment and shall identify third party liability coverage, including Medicare and other insurance, and if applicable seek such third-party liability payment before submitting claims to United.

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

f. **Cultural Competency and Access.** Provider shall participate in United's and the State's efforts to efforts to promote the delivery of services in a culturally competent manner to all Members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of sex, and shall provide interpreter services in a Member's primary language and for the hearing impaired for all appointments and emergency services. Provider shall provide information to Member regarding treatment options and alternatives, as well as information on complaints and appeals, in a manner appropriate to the Member's condition and ability to understand. Provider shall provide physical access, reasonable accommodations, and accessible equipment for Member with physical or mental disabilities.

g. **Data; Reports.** Provider agrees to cooperate with and release to United any information necessary for United to comply with the State Contract and federal and state law, to the extent applicable to Provider in performance of the Agreement. Such information includes timely submission of reports including child health check-up reporting, EPSDT encounters, and cancer screening encounters, if applicable, as well as complete and accurate encounter data in accordance with the requirements of United and the State. By submitting data to United, Provider represents and attests to United and the State that the data is accurate, complete and truthful, and upon United's request Provider shall certify in writing, that the data is accurate, complete, and truthful, based on Provider's best knowledge, information and belief.

h. **Fraud, Waste, and Abuse.** Provider understands and agrees that each claim the Provider submits to United constitutes a certification that the Provider has complied with all applicable Medicaid laws, regulations and program instructions in connection with such claims and the services provided therein. Provider's payment of a claim 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 or United provides notice that a credible allegation of fraud exists and there is a pending investigation. Provider's payment of a claim may also be temporarily suspended or adjusted if the Provider bills a claim with a code that does not match the service provided. United performs coding edit procedures based primarily on National Correct Coding Initiative (NCCI) policies and other nationally recognized and validated policies. Provider agrees that it will provide medical records to United upon its request in order to determine appropriateness of coding. Further, when Provider t has received an overpayment, Provider will return the overpayment to United within 60 calendar days after the date on which the overpayment was identified, and to notify United in writing of the reason for the overpayment.

i. **Government Audit; Investigations.** 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.

j. **Hold Harmless.** Provider will accept, as payment in full, the amounts paid by United to Provider for Covered Services to Member, plus any deductible, coinsurance or copayment required to be paid by the Member, and will hold Member harmless in the event that United cannot or will not pay for such Covered Services. If a service is not a Covered Services, prior to providing the

service, Provider shall inform the Member the service is not a Covered Service and have the Member acknowledge the information. If the Member still requests the service, Provider shall obtain such acknowledgement in writing prior to rendering the service. If United determines a Member 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.

k. **Marketing.** Provider will comply with 42 C.F.R. § 438.104 and any applicable State Program guidance and regulations related to marketing materials including, but not limited to, seeking approval from the Medicaid Agency prior to distributing any marketing materials to Members.

l. **Physician Incentive Plans.** If Provider participates in a physician incentive program ("PIP"), Provider must comply with the requirements set forth in 42 C.F.R. §§ 422.208 and 422.210, including but not limited to the following: a) Provider will not make specific payment, directly or indirectly, to a physician or physician group as an inducement to reduce or limit Medically Necessary services furnished to any Member; and b) if the PIP places Provider at substantial financial risk for services that Provider does not furnish itself, Provider must have stop-loss protection in accordance with 42 C.F.R. § 422.208(f).

m. **Preventable Conditions.** No payment will be made by United to a Provider for provider preventable conditions, as identified in the State Program. Provider shall identify and report to United any provider preventable conditions in accordance with 42 C.F.R. §§ 434.6(a)(12)(i) and (ii) and 42 C.F.R. § 447.26(d).

n. **Privacy; Confidentiality.** Provider shall safeguard Member privacy and confidentiality including, but not limited to, the privacy and confidentiality of any information that identifies a particular Member and shall comply with all federal and state laws and State Program requirements regarding confidentiality and disclosure of medical records or other health and enrollment information.

o. **Quality; Utilization Management.** Provider agrees to cooperate with United's quality 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 United or as required under the State Contract to ensure that Members have due process for their complaints, grievances, appeals, fair hearings or requests for external review of adverse decisions made by United or Provider. Provider shall adhere to the quality assurance and utilization review standards of the State Program and shall monitor quality and initiate corrective action to improve quality consistent with the generally accepted level of care.

p. **Records.** As required under State or federal law or the State Contract, Provider shall maintain an adequate record keeping system for recording services, charges, dates and all other commonly accepted information elements for services rendered to Members. Medical records and supporting management systems shall include all pertinent information related to the medical management of each Member. Other records shall be maintained as necessary to clearly reflect all actions taken by Provider related to services provided under the State Contract.

Provider shall retain all records including, as applicable, grievance and appeal records and any other records related to data, information, and documentation for a period of not less than 10 years from the close of the Agreement, or such other period as required by law.

Provider acknowledges and agrees that the State, the U.S. Department of Health and Human Services and other authorized federal and state personnel shall have complete access to all records pertaining to services provided to Members. Provider shall provide immediate access to facilities, records and supportive materials pertinent to the State Contract for State or Federal fraud investigators.

iv) **Stark Law and the Anti-Kickback Statute.** 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 (see, 42 U.S.C. 1395nn; 42 U.S.C. 1320a–7b; 42 C.F.R. § 411.350).

3.5 **Disclosure.** Provider must be screened and enrolled into the State's Medicaid or CHIP program, as applicable, and submit disclosures to Department 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. Additionally, Provider must cooperate with the Department for submission of fingerprints upon a request from the Department or CMS in accordance with 42 CFR 455.434.

3.6 **Requirements for Specific Provider Types.** The following provisions apply to certain provider types as indicated:

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

ii) **Clinical Laboratory Improvements Act (CLIA) certification or waiver.** As applicable, if Provider performs any laboratory tests on human specimens for the purpose of diagnosis and/or treatment, Provider agrees to acquire and maintain the appropriate CLIA certification or waiver for the type of laboratory testing performed. Provider further agrees to provide a copy of the certification if requested by United. A State authorized license or permit that meets the CLIA requirements may be substituted for the CLIA certificate pursuant to State law. Medicare and Medicaid programs require the applicable CLIA certification or waiver for the type of services performed as a condition of payment. Provider must include the appropriate CLIA certificate or waiver number on claims submitted for payment for laboratory services.

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

iv) **Long-Term Services and Supports (LTSS) Providers.** Any LTSS Covered Services under the State Contract that could be authorized through a waiver under section 1915(c)

of the Social Security Act (the "Act") or a State Program amendment authorized through sections 1915(i) or 1915(k) of the Act must be delivered in settings consistent with 42 C.F.R. § 441.301(c)(4).

iv) **Mental Health and Substance Use Providers.** Providers who provide Mental Health and Substance Use services to Members 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.

3.7 Termination. In the event of termination of the Agreement, Provider shall promptly supply to united all information necessary for the reimbursement of any outstanding Medicaid claims. Neither United nor Provider has the right to terminate the Agreement without cause. If the Agreement is terminated with cause, United will provide a written statement to Provider of the reason or reasons for the termination with cause. In the event of termination of the Agreement, Provider shall promptly supply to United all information necessary for the reimbursement of any outstanding Medicaid claims and shall assist with transitioning Members' medical records and other relevant information as directed by United or that Member.

SECTION 4
UNITED REQUIREMENTS

4.1 Prompt Payment. United shall pay Provider pursuant to the State Contract and applicable State and federal laws and regulations for prompt payment and clean claims, including but not limited to 42 U.S.C. 1396u-2(f) and 42 CFR 447.46, as applicable and as may be amended from time to time. Unless a different timeframe is set forth in the Agreement., 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 applicable State Contract. Unless United otherwise requests assistance from Provider, United will be responsible for third party collections in accordance with the terms of the applicable State Contract.

United will pay 90% of clean claims from physicians in an individual or group practice which can be processed without obtaining additional information from the physician or from a third party within thirty (30) days of the date of receipt of the claim. United will pay 99% of clean claims within sixty (60) days of the date of receipt of the claim.

4.2 Provider Discrimination Prohibition. United shall not discriminate with respect to participation, reimbursement, or indemnification of a provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification. In addition, United will not discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatment. This provision shall not be construed as prohibiting United from limiting a provider's participation to the extent necessary to meet the needs of Members. This provision also is not intended and shall not interfere with measures established by United that are designed to maintain quality of care practice standards and control costs.

4.3 Provider-Member Communications. United may not prohibit, or otherwise restrict, Provider, when acting within the lawful scope of practice, from advising or advocating on behalf of a Member for the following: (i) the Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered; (ii) any information the

Member needs in order to decide among all relevant treatment options; (iii) the risks, benefits, and consequences of treatment or non-treatment; or (iv) the Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

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

Providers are not prohibited from discussing treatment options with Members that may not reflect United's position or may not be covered by United.

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

SECTION 5
OTHER REQUIREMENTS

5.1 Compliance with State Contract. All tasks performed under the Agreement shall be performed in accordance with the requirements of the applicable State Contract, as set forth in this Appendix, the Guide to the Senior Care Options Program for MassHealth Providers distributed by the Department, and applicable provider manual(s), protocols, policies and procedures that United has provided, delivered or made available to Provider. The applicable provisions of the State Contract are incorporated into the Agreement by reference. Nothing in the Agreement relieves United of its legal responsibilities under the applicable State Contract; United remains fully responsible for meeting all terms and requirements of the State Contract. If any provision of the Agreement or this Appendix is in conflict with provisions of the applicable State Contract, the terms of the State Contract shall control and the terms of the Agreement or this Appendix in conflict with those of the State Contract will be considered waived.

5.2 Monitoring. United shall perform ongoing monitoring (announced or unannounced) of services rendered by Provider under the Agreement and shall perform periodic formal reviews of Provider according to a schedule established by the State, consistent with industry standards or State managed care organization laws and regulations or requirements under the State Contract. As a result of such monitoring activities, United shall identify to Provider any deficiencies or areas for improvement mandated under the State Contract and Provider and United shall take appropriate corrective action. Provider shall comply with any corrective action plan initiated by United and/or required by the State Program.

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

5.4 Delegation. Any delegated duties and reporting responsibilities shall be set forth in the Agreement or other written delegation agreement or addendum between the parties.

5.5 Regulatory Amendment. United may unilaterally amend this Appendix to comply with applicable laws and regulations and the requirements of applicable regulatory authorities including, but not limited to, Medicaid Agency. Unless such laws, regulations, or regulatory authority(ies) direct otherwise, the signature of Provider will not be required in order for the amendment to take effect.

Section 6
State Specific Requirements

6.1 Medically Necessary or Medical Necessity. In addition to Section 3.1(iii) and as required by the State Contract, Medically Necessary or Medical Necessity are services shall be provided consistent with all Member protections and benefits provided by Medicare and MassHealth, and that provide the Member with coverage to at least the same extent, and with the cumulative effect, as provided by the combination of Medicare and MassHealth.

Per Medicare, Medically Necessary Services are those that are reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body Member, or otherwise medically necessary under 42 U.S.C. § 1395y.

In accordance with Medicaid law and regulations, services shall be provided in accordance with MassHealth regulations, including in accordance with 130 CMR 450.204. Medically Necessary services are those services:

- That are reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the Member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a disability, or result in illness or infirmity; and
- For which there is no other medical service or site of service, comparable in effect, available, and suitable for the Member requesting the service that is more conservative or less costly.
- Medically Necessary services shall be of a quality that meets professionally recognized standards of health care and shall be substantiated by records including evidence of such medical necessity and quality.

In addition, a service is Medically Necessary when

- It may attain, maintain, regain, improve, extend, or expand the Member's health, function, functional capacity, overall capacity, or otherwise support the Member's ability to do so; or
- A delay, inaction, or a reduction in amount, duration, or scope, or type or frequency of a service may jeopardize the Member's health, life, function, functional capacity, or overall capacity to maintain or improve health or function.

6.2 Clinical Information. Provider must provide Member's clinical information to other providers, as necessary, to ensure proper coordination and behavioral health treatment of Members who express suicidal or homicidal ideation or intent, consistent with state law.

6.3 Behavioral Health Inpatient and 24-hour Diversionary Services. Behavioral Health Inpatient and 24-hour Diversionary Services Provider shall accept for admission or treatment all Members

for whom United has determined admission or treatment is medically necessary, regardless of clinical presentation, as long as a bed is available in an age-appropriate unit.

Provider shall coordinate treatment and discharge planning with the state agencies (e.g., DMH, DDS) with which the Member has an affiliation, and in no such case shall Provider discharge patients who are homeless or who have unstable housing without a plan for housing.

Provider shall have human rights and restraint and seclusion protocols that are consistent with the DMH's Human Rights and Restraint Seclusion Policy and regulations and include training of the Provider's staff and education for Members regarding human rights. Provider shall have a human rights officer, who shall be overseen by a human rights committee, and who shall provide written materials to Members regarding their human rights, in accordance with DMH's Human Rights and Restraint and Seclusion Policy and with applicable DMH regulations and requirements.

Provider shall coordinate with all contracted Community Behavioral Health Centers (CBHCs) in United's Service Area(s), including procedures to credential and grant admitting privileges to AMCI Provider psychiatrists, if necessary.

As needed, Provider shall participate in or convene regular meetings and conduct ad hoc communication on clinical and administrative issues with CBHCs to enhance the continuity of care for Members.

6.4 Community Behavioral Health Center (CBHC). The response time for face-to-face crisis evaluation by CBHCs shall not exceed one our from notification by telephone from the referring party or from the time of presentation by Member.

6.5 Access to Services. Provider shall not bill Member for missed appointments or refuse to provide services to any Member because that Member has missed appointments or has an outstanding debt with Provider from a time prior to his or her enrollment in the State Program. If a Member has missed appointments, Provider shall work with United to assist that Member in keeping his or her future appointments.

6.6 Member Access to Records. Provider also shall ensure that medical information is released pursuant to court orders or subpoenas and that Member has timely access to medical records and information that pertain to them, in accordance with applicable law.

6.7 Cost-Sharing. A Member's cost-share responsibility depends on the Member's level of Medicaid eligibility, full versus partial Medicaid. Provider's obligation to hold Member harmless, includes a prohibition against charging Member coinsurance, co-payments, deductibles, financial penalties, or any other amount in full or in part for any service provided under the SCO Program and OneCare Program.

6.8 Dual Eligible Members. Provider agrees that in no event, including but not limited to, non-payment by the State Medicaid agency or other applicable regulatory authority, other State source, or breach by United of the Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Dual Eligible Member, person acting on behalf of the Dual Eligible Member, or United (unless notified otherwise) for Medicare Part A and B Cost Sharing. Instead, Provider will either: (a) accept payment made by or on behalf of United as payment in full; or (b) bill the appropriate State source for such Cost Sharing amount.

6.9 Notification to Primary Care Provider (PCP). As applicable, Provider shall notify the Member's PCP of any screening or treatment of Covered Services, including Emergency Services.

6.10 Centralized Enrollee Record. As applicable, Provider shall comply with United policies and statutory and regulatory requirements applicable to the Centralized Enrollee Record and other Member medical records. This shall include, at a minimum, compliance with all federal and State legal requirements as they pertain to the confidentiality of Member records and all confidentiality protections established by United. Provider shall make appropriate and timely entries in the Centralized Enrollee Record describing the care provided, diagnoses determined, medications prescribed, and treatment plans developed (as applicable). The documentation included in the Centralized Enrollee Record must be consistent with current professional standards and be current, detailed, and organized in a manner that permits effective patient care and quality review. If Provider is a PCP, Provider shall be responsible for maintaining the Centralized Enrollee Record for Members residing in the community. Nursing home Providers will be responsible for maintaining the Centralized Enrollee Record for Members who reside in such nursing home. Additional requirements for the Centralized Enrollee Record are set forth in the provider manual.

6.11 Conflicts of Interest. Provider may not, for the duration of the Agreement, have any interest that will conflict, as determined by the Department, with the performance of services under the applicable State Contract or that may otherwise be anticompetitive.

6.12 Conflicts of Laws. Provider acknowledges and agrees that Massachusetts general law or Massachusetts regulation will prevail if there is a conflict with the state law or state regulation where Provider is based.

6.13 Independent Contractor Relationship. Provider, its employees, subcontractors, and any other of its agents shall, in the performance of the Agreement, act in an independent capacity and not as officers or employees of the federal government, the State, the Department, or CMS.

6.14 State and Federal Funds. Provider acknowledges and agrees that United receives State and federal payments under the State Contracts and CMS Contract and that payments Provider receives from or on behalf of United are, in whole or in part, from State and federal funds. Provider is therefore subject to certain laws that are applicable to individuals and entities receiving State and federal funds.

6.15 Data Requirements. Provider must provide to United and/or the Department all information the Department requires under the applicable State Contract related to the performance of Provider's responsibilities, including encounter data, as well as non-medical information for the purposes of research and evaluation, and any information the Department requires to comply with all applicable federal and State laws and regulations. Such data must include, but isn't limited to, information pertaining to (a) substance use disorders, (b) births to Members, (c) clinical assessment and outcomes data, and (d) provider incentives. As applicable, Provider shall submit to United all risk adjustment data as defined in 42 CFR 422.310(a). Provider shall send to United all risk adjustment data and other Medicare Advantage program-related information as may be requested by United, within the timeframes specified and in a form that meets Medicare Advantage program requirements. By submitting data to United, Provider represents, and upon United's request shall certify in writing, that the data is accurate, complete, and truthful, based on Provider's best knowledge, information and belief.

6.16 Nonprofit Organization. Provider shall promptly notify United if it is currently, or at any time during the term of the Agreement becomes, certified as a non-profit organization by the Commonwealth's Supplier Diversity Office.