PENNSYLVANIA GOVERNMENT PROGRAMS REGULATORY REQUIREMENTS APPENDIX

DOWNSTREAM PROVIDER

THIS PENNSYLVANIA GOVERNMENT PROGRAMS REGULATORY REQUIREMENTS APPENDIX (this "Appendix") supplements and is made part of the provider agreement (the "Agreement") between **Ear Professionals International Corporation d/b/a EPIC Hearing Healthcare and d/b/a UnitedHealthcare Hearing** ("Subcontractor") and the provider named in the Agreement ("Provider").

SECTION 1
APPLICABILITY

This Appendix 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 under the State of Pennsylvania Medical Assistance managed care program (the "Medical Assistance Program") and the Children's Health Insurance Program ("CHIP") (each a "State Program" and collectively, the "State Programs") 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 contracts between the State and Health Plan (the "State Contracts" as defined herein). The State contracts and applicable State and federal law require that the provisions contained in this Appendix be part of the Agreement. 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 contracts outside the scope of this Appendix or unless otherwise required by law. In the event Subcontractor is required to amend or supplement this Appendix 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.

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. **Act 68:** Article XXI of the Insurance Company Law of 1921, added by Act 68 of 1998, governing quality health care accountability and protection (40 P.S. §§ 991.2101 et seq.) and including its implementing regulations as promulgated by the Pennsylvania Department of Health and Department of Insurance.

2.2. **Agreement:** A written agreement between Subcontractor and a Provider that has been approved by the appropriate regulatory agency and is for the provision of medical or professional services to Covered Persons enrolled in a State Program.

2.3. **Children's Health Insurance Program (CHIP):** The name of the Pennsylvania program that provides free and subsidized health care services in accordance with a

portion of Act 1998-68, 40 P.S. §§ 991.2301 et seq. For purposes of this Appendix, CHIP Program may refer to the State agency(ies) responsible for administering the CHIP Program.

2.4. **Covered Person:** For the CHIP Program, Covered Person refers to an individual under the age of nineteen (19) years who has been determined to be eligible for the CHIP Program and is enrolled with Health Plan under such program. For the Medical Assistance Program, Covered Person refers to an individual enrolled with Health Plan under the Medical Assistance Program for whom Health Plan has agreed to arrange for the provision of Covered Services under the provisions of the Medical Assistance Program. A Covered Person may also be referred to as a Member, Enrollee, Customer or similar term in the Agreement.

2.5. **Covered Services:** A health care service or product for which a Covered Person is enrolled with Health Plan to receive coverage under a State Contract.

2.6. **Department of Health or DOH:** The Department of Health of the Commonwealth of Pennsylvania.

2.7. **Department of Insurance or DOI:** The Insurance Department of the Commonwealth of Pennsylvania.

2.8. **Department of Human Services or DHS:** The Department of Human Services of the Commonwealth of Pennsylvania.

2.9. **Early and Periodic Screening, Diagnosis and Treatment ("EPSDT"):** Items and services which must be made available to Medicaid recipients under the age of twenty-one (21) upon a determination of Medical Necessity and required by federal law at 42 U.S.C. § 1396d(r).

2.10. **Encounter:** Any Covered Service provided to a Covered Person, regardless of whether it has an associated claim.

2.11. **Encounter Data:** A record of any Covered Service provided to a Covered Person, including encounters reimbursed through capitation, fee-for-service, or other methods of compensation, regardless of whether payment is due or made.

2.12. **Health Care Provider:** A licensed hospital or health care facility, medical equipment supplier or person who is licensed, certified or otherwise regulated to provide health care services under the laws of the Commonwealth of Pennsylvania or state(s) in which the entity or person provides services, including a physician, podiatrist, optometrist, psychologist, physical therapist, certified registered nurse practitioner, registered nurse, nurse midwife, physician's assistant, chiropractor, dentist, pharmacist, or an individual accredited or certified to provide behavioral health services.

2.13. **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 on behalf of Health Plan pursuant to one or more State Contracts. For purposes of this Appendix, Health Plan refers to UnitedHealthcare of Pennsylvania, Inc.

2.14. **Medical Assistance Program:** Pennsylvania's managed care program for Medicaid recipients, which includes the HealthChoices Program. For purposes of this Appendix, Medical Assistance Program may refer to the State agency(ies) responsible for administering the Medical Assistance Program.

2.15. **Primary Care Practitioner or PCP:** An appropriately licensed and credentialed physician, physician group or a certified registered nurse practitioner operating under the scope of his/her licensure, and who is responsible for supervising, prescribing, and providing primary care services; locating, coordinating and monitoring other medical care and rehabilitative services; and maintaining continuity of care on behalf of a Covered Person.

2.16. **Provider or Participating Provider:** An appropriately licensed and credentialed Health Care Provider who has entered into an Agreement for the delivery of Covered Services to Covered Persons under one or more State Contracts.

2.17. **State:** The Commonwealth of Pennsylvania or its designated regulatory agencies.

2.18. **State Contracts:** Health Plan's contracts with the State for the purpose of providing and paying for Covered Services to Covered Persons enrolled in the Medical Assistance (Medicaid managed care) Program and CHIP Program (each a "State Contract" and collectively, the "State Contracts"). Health Plan's contract(s) with DHS for the Medical Assistance Program may be specifically referred to herein as the "Medical Assistance State Contract" and Health Plan's contract with DOI for the CHIP Program may be specifically referred to herein as the "CHIP State Contract."

2.19. **State Programs.** The Medical Assistance (Medicaid managed care) and CHIP Programs offered by the Commonwealth of Pennsylvania (each a "State Program" and collectively, the "State Programs"). For purposes of this Appendix, State Program(s) may refer to the State agency(ies) responsible for administering the State Program(s).

2.20. **Substantial Financial Risk:** Financial risk set at greater than twenty-five percent (25%) of potential payments for Covered Services, regardless of the frequency of assessment (i.e., collection) or distribution of payments. The term "potential payments" means the maximum anticipated total payments that the physician or physician group could receive if the use or cost of referral services were significantly low. The cost of referrals, then, must not exceed that twenty-five percent (25%) level, or else the financial arrangement is considered to put the physician or group at Substantial Financial Risk.

SECTION 3
PROVIDER REQUIREMENTS

The State Programs, through contractual requirements and federal and State statutes and regulations, require the Agreement to contain certain conditions that Health Plan, Subcontractor, 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 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:

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

ii) Emergency Services: For the Medical Assistance Program, Emergency Services mean covered inpatient and outpatient services that: (1) are furnished by a provider that is qualified to furnish such services under Title XIX of the Social Security Act; and (2) are needed to evaluate or stabilize an Emergency Medical Condition. For the CHIP Program, Emergency Services mean any health care services provided to a Covered Person after the sudden onset of an Emergency Medical Condition and include emergency transportation and related emergency services provided by a licensed ambulance service.

iii) Medically Necessary: A service or benefit that is compensable under the Pennsylvania Medical Assistance Program or CHIP Program (as applicable) and meets any one of the following standards:

a) The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability.

b) The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.

c) The service or benefit will assist the Covered Person to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Covered Person and those functional capacities that are appropriate for Covered Persons of the same age.

Determination of Medical Necessity shall be made by qualified and trained Health Care Providers, exercising prudent clinical judgment, based on medical information provided by the Covered Person, the Covered Person's family/caretaker and the PCP, as well as any other Providers, programs or agencies that have evaluated the Covered Person. Determination of Medical Necessity for Covered Services, whether made on a prior authorization, concurrent review, retrospective review, or exception basis, must be documented in writing.

iv) Urgent Medical Condition: Any illness, injury or severe condition which under reasonable standards of medical practice would be diagnosed and treated within a twenty-four (24) hour period and if left untreated could rapidly become a crisis or Emergency Medical Condition. The term also includes situations where a person's discharge from a hospital will be delayed until services are approved or a person's ability to avoid hospitalization depends upon prompt approval of services.

3.2. **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. Furthermore, Provider shall keep its information up-to-date within the State's PROMISe ™ system (or, any other system as required by the State). 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 is on the State's exclusion list or has been terminated or suspended from the Medicare, Medicaid or CHIP program in any state.

3.3. **Unique Identifier.** Physician Providers must have a unique identifier in accordance with the system established under § 1173(b) of the Social Security Act, as may be amended from time to time.

3.4. **Recipient Restriction Program.** If Provider participates in the Medical Assistance Program, Provider shall cooperate with Health Plan's and DHS's Medicaid recipient restriction program.

3.5. **Covered Persons.** Provider shall provide to Covered Persons those services described in the Agreement that are applicable to the State Program in which the Covered Person is enrolled. Provider shall accept a female Covered Person's enrollment with Health Plan, or her identification card, as sufficient to provide services to her newborn for those newborn services that are Covered Services under the applicable State Program.

3.6. **Referrals.** All services provided to a Covered Person shall comply with the referral and/or authorization requirements under the applicable State Program, as described in the Agreement and/or applicable provider manual(s). Provider shall not make inappropriate referrals for designated health services to health care entities with which Provider or a member of Provider's family has a financial relationship, pursuant to federal anti-kickback and physician self-referral laws that prohibit such referrals.

3.7. **Accessibility Standards.** Provider must provide for timely access to Covered Person appointments in accordance with the appointment availability requirements established by Health Plan and Subcontractor pursuant to the requirements of the State Contracts, including without limitation, appointments for preventative care, urgent care, routine sick care, and well care.

3.8. **Hours of Operation; Appointments.** 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 or other government program enrollees if Provider serves only Medicaid or other government program beneficiaries. Provider must not subject a Covered Person to segregated, separate or different treatment, including a different place or time, from that provided to other public or private patients, except where Medically Necessary. As applicable, Provider will make Covered Services available 24 hours a day, 7 days a week when medically necessary.

3.9. **PCPs.** Providers who are PCPs shall comply with all additional requirements pertaining to PCPs under the applicable State Contract, including, but not limited to the following:

i) PCPs who serve Medical Assistance Covered Persons under the age of twenty-one (21) years are responsible for conducting all EPSDT screens for individuals on their panel under the age of twenty-one (21). If the PCP is unable to conduct the necessary EPSDT screens, the PCP must arrange to have the necessary EPSDT screens conducted by another Participating Provider and ensure that all relevant medical information, including the results of the EPSDT screens, is incorporated into the Covered Person's PCP medical record. PCPs must report Encounter Data associated with EPSDT screens to Health Plan or Subcontractor, as directed, using a format approved by DHS, within ninety (90) days from the date of service.

ii) PCPs who serve Medical Assistance Covered Persons under the age of twenty-one (21) years must contact those Covered Persons identified by Health Plan in quarterly Encounter lists as not complying with EPSDT periodicity and immunization schedules for children and shall identify to Health Plan or Subcontractor, as directed, any such Covered Persons who have not come into compliance with the EPSDT periodicity and immunization schedules within one (1) month of notification to the PCP by Health Plan or Subcontractor of noncompliance. PCPs shall document the reasons for noncompliance, where possible, and efforts made to bring the Covered Person's care into compliance with the EPSDT standards.

iii) PCPs shall contact: (a) new Medical Assistance Covered Persons identified by Health Plan in quarterly Encounter lists who have not had an Encounter during the first six (6) months of enrollment with Health Plan or who have not complied with the scheduling requirements under the Medical Assistance State Contract; and (b) all Medical Assistance Covered Persons who have not had an Encounter during the previous twelve (12) months or within the time frames required under the Medical Assistance State Contract.

3.10. **Health Care Facilities and Ambulatory Surgical Centers.** Providers that are health care facilities and ambulatory surgical facilities shall develop and implement, in accordance with P.L. 154, No. 13 known as the Medical Care Availability and Reduction of Error (Mcare) Act, an internal infection control plan that is established for the purpose of improving the health and safety of patients and health care workers and includes effective measures for the detection, control and prevention of health care-associated infections.

3.11. **Continuity of Care.** Except as provided in this section, if Health Plan or Subcontractor terminates the Agreement, Provider shall continue to furnish Covered Services to any Covered Person who, at the Covered Person's option, desires to continue an ongoing course of treatment with Provider for a transitional period of up to sixty (60) days from the date the Covered Person was notified by Health Plan or Subcontractor of the Agreement's termination or pending termination. Health Plan and Subcontractor, in consultation with Provider and a Covered Person, may extend the transitional period if clinically appropriate. In the case of a Covered Person in the second or third trimester of pregnancy at the time of notice of the termination, the transitional period shall extend through post-partum care related to delivery. Any Covered Services provided during the transitional period shall be covered by Health Plan under the same terms and conditions as applicable to Participating Providers. Notwithstanding the foregoing, if Health Plan or Subcontractor terminates the Agreement for cause, including but not limited to breach of

contract, fraud, criminal activity or posing a danger to Covered Persons or the health, safety or welfare of the public as determined by Health Plan or Subcontractor, Health Plan shall not be responsible for any Covered Services provided to a Covered Person by Provider following the effective date of termination. Nothing in this section shall require Health Plan to provide health services that are not otherwise covered as Covered Services under the terms and conditions of the Agreement. If a Provider who has a capitated arrangement with Subcontractor terminates the Agreement for any reason, such Provider shall provide services to Covered Persons assigned to the Provider through the end of the month in which the termination becomes effective.

3.12. **Continuity of Care, Capitation or Premium Paid.** In the event of Health Plan's or Subcontractor's insolvency or other cessation of operations, Provider shall continue to provide benefits to Covered Persons, including Covered Persons in an inpatient setting, through the period for which the applicable capitation or premium has been paid to Health Plan by the State.

3.13. **Hold Harmless.** In no event, including but not limited to nonpayment by Health Plan or Subcontractor, insolvency of Health Plan, Subcontractor or Provider or breach of the Agreement, shall Provider, or Provider's facility-based physician groups, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Covered Persons or other persons or entities acting on behalf of the Covered Person, other than Health Plan or Subcontractor, for services provided under the Agreement. A Covered Person is not liable to Provider for any services for which Health Plan is liable or for Health Plan's debts in the event of insolvency. This provision does not prohibit Provider from collecting any allowable cost-sharing (e.g., co-payments, deductibles, and/or co-insurance) in accordance with the terms of the Covered Person's benefit plan and the applicable State Contract. Provider shall also be prohibited from charging Covered Persons for missed appointments if such practice is prohibited under the applicable State Contract or applicable law.

This hold harmless provision shall survive termination of the Agreement for any reason, including breach due to insolvency, and shall be construed for the benefit of Covered Persons. This hold harmless provision shall also supersede any written or oral agreement currently in existence or entered into at a later date between Provider and a Covered Person, or person(s) acting on the Covered Person's behalf. No modification, addition, or deletion to the provisions of this section shall become effective until approved by DOH and DHS.

3.14. **Data.** Provider shall submit to Health Plan or Subcontractor, as directed, timely and complete claims, Encounter Data and other utilization data, reports and clinical information as required under the applicable State Contract and as specified in the applicable provider manual(s) and/or other protocols, policies and procedures provided to Provider. Encounter Data for all services must be submitted within the time frames established by Health Plan and Subcontractor pursuant to the State Contracts, regardless of whether reimbursement for such services is made by Health Plan or Subcontractor either directly or indirectly through capitation. Provider shall certify the accuracy, completeness, and truthfulness of all claims and data submitted. 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.

3.15. **Grievance; Complaints.** Provider agrees to comply with Health Plan's policies and procedures for Covered Person complaints and grievances, including but not limited to any reporting requirements established by Health Plan pursuant to the requirements of the applicable State Contract.

3.16. **Denial of Services.** Provider shall not deny services to a Medicaid recipient during the period that the recipient is covered under the Medicaid fee-for-service program prior to the effective date of the recipient's enrollment with Health Plan under the Medical Assistance Program.

3.17. **Cultural Competency and Access.** 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 applicable State Contract or as otherwise may be required by law. Provider shall provide physical access, reasonable accommodations, and accessible equipment for Covered Persons with physical or mental disabilities.

3.18. **Insurance Requirements.** Provider must maintain professional malpractice and all other types of insurance in such amounts as required by all applicable laws. Upon request, Provider shall provide Health Plan and Subcontractor evidence of such insurance coverage.

3.19. **Behavioral Health.** If applicable, Provider shall coordinate with behavioral health providers in the treatment of a Covered Person, including:

i) complying with all applicable laws and regulations pertaining to the confidentiality of Covered Person medical records, including obtaining any required written Covered Person consents to disclose confidential medical records;

ii) making referrals for social, vocational education or human services when a need for such service is identified through assessment;

iii) providing health records if requested by a behavioral health provider;

iv) notifying the behavioral health provider of all prescriptions, making sure behavioral health clinicians have complete, up-to-date records of medications and, when deemed advisable, checking with the behavioral health provider before prescribing medication;

v) being available to the behavioral health provider on a timely basis for consultations.

3.20. **Nondiscrimination and Sexual Harassment.** During the term of the Agreement, Provider agrees to comply with the following nondiscrimination and sexual harassment clause:

i) Provider shall accept and treat Covered Persons without regard to race, color, religious creed, ancestry, age, familial status, sex, sexual preference, national origin, source of payment or any other protected status under State or federal law.

ii) In the hiring of any employees for the manufacture of supplies, performance of work, or any other activity required under the Agreement, Provider or any person acting on behalf of Provider shall not by reason of gender, race, creed or color discriminate against any citizen of the State who is qualified and available to perform the work to which the employment relates.

iii) Neither Provider nor any person on Provider's behalf shall in any manner discriminate against or intimidate any employee involved in the manufacture of supplies, the performance of work or any other activity required under the Agreement on account of gender, race, creed or color.

iv) Provider shall establish and maintain a written sexual harassment policy and shall inform its employees of the policy. Such policy must contain a notice that sexual harassment will not be tolerated and employees who practice it will be disciplined.

v) Provider shall not discriminate by reason of gender, race, creed or color against any subcontractor or supplier who is qualified to perform the work to which the contract relates.

vi) Provider shall furnish all necessary employment documents and records, and permit access to its books, records, and accounts, to the contracting officers for the State Contracts and the Department of General Services' Bureau of Contract Administration and Business Development for purposes of investigation to ascertain compliance with the provisions of this nondiscrimination/sexual harassment clause. If Provider does not possess documents or records reflecting the necessary information requested, it shall furnish such information on reporting forms supplied by the contracting officer(s) or the Bureau of Contract Administration and Business Development.

3.21. **Americans with Disabilities Act.** Provider shall comply with all applicable provisions of the Americans with Disabilities Act (42 U.S.C. § 12101 et seq.) and regulations promulgated thereunder, as may be amended from time to time. Pursuant to 28 CFR § 35.101 et seq., Provider understands and agrees that it shall not cause any individual with a disability to be excluded from participation in the Agreement or from activities provided for under the Agreement on the basis of disability. As a condition of entering into the Agreement, Provider agrees to comply with the "General Prohibitions Against Discrimination," 28 CFR § 35.130, and all other regulations promulgated under Title II of the Americans With Disabilities Act that are applicable to all benefits, services, programs, and activities provided by the State through contracts with outside contractors (including Health Plan). Provider shall be responsible for and agrees to indemnify and hold harmless the State from all losses, damages, expenses, claims, demands, suits, and actions brought by any party against the State as a result of Provider's failure to comply with the provisions of this section.

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

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

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

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

iv) Labor Anti-Injunction Act, 43 P.S. §§ 206a – 206r, and the Pennsylvania Labor Relations Act, 43 P.S. §§ 211.1 – 211.13.

3.23. **Third Party Resources.** Provider shall report to Subcontractor and/or Health Plan, as directed, all new third party resources identified through the provision of medical services to Covered Persons, including specifically for Medical Assistance Covered Persons, those third party resources which previously did not appear on the recipient information files provided to Health Plan by DHS.

3.24. **Records Retention and Access.** Provider shall comply with the following requirements related to books and records:

i) Maintenance. Provider shall maintain books, records, documents and other evidence related to services, expenditures, revenues, and other financial and programmatic activity under the Agreement. This shall include but not be limited to (as applicable) reports submitted to the State Programs and source information used in preparation of such reports, financial statements, records relating to quality of care, medical records and claims, and prescription files. Records other than medical records may be kept in an original paper state or preserved on micro media or electronic format and must be legible and readily retrievable. Medical records shall be maintained in accordance with subsection (b) below. Books, records, documents and other evidence related to the Agreement, including source documents, shall be maintained for a minimum of ten (10) years from termination of the Agreement or such longer period as required by law, unless an audit is in progress or audit findings are yet unresolved, in which case records and other documents referenced herein shall be maintained until completion or final resolution of the audit.

ii) Medical Records. Provider shall comply with all standards for practice and medical record keeping specified by Health Plan, Subcontractor and applicable federal and State laws and regulations, including specifically Act 68. Medical records shall be maintained in a detailed and comprehensive manner which conforms to good professional medical practice, permits effective professional medical review and medical audit processes, and facilitates an adequate system for follow-up treatment. Medical records must be legible, signed, dated and in a format acceptable to the applicable State Program. Medical records shall be maintained in electronic or paper form for at least two (2) years before they are converted to any other form and all forms must be readily available for review.

iii) Government Audit and Access. Provider shall assure that the applicable State Program(s) and other authorized State and federal agencies, including but not limited to appropriate representatives of the U.S. Department of Health and Human Services ("DHHS"), the U.S. Comptroller General and the Office of the Inspector General and their designees or their authorized representatives, have ready access to any and all documents and records of transactions pertaining to the provision of services to Covered Persons and amounts paid or payable under the State Contracts. The State and DHHS shall also have the right to evaluate through inspection or other means, the quality, appropriateness and timeliness of services performed under the State Contracts. Provider shall, at Provider's own expense, make all books, records, documents and other evidence maintained by Provider in accordance with subsection (a) available for review, audit or evaluation by the State, its designated representatives or federal agencies during the term of the Agreement and the required record retention period specified in subsection (a). Access shall be provided either on-site, during normal business hours or through the mail and shall be available at Provider's chosen location, subject to approval by the State. Records sent by mail shall be sent to the requesting entity in the form of accurate, legible paper copies, unless otherwise indicated, within fifteen (15) calendar days of such request and at no expense to the requesting entity. Provider shall fully cooperate with any and all reviews and/or audits by authorized State or federal agencies or their agents by assuring that appropriate employees and involved parties are available for interviews relating to reviews or audits. Such audits may include, but not be limited to: (i) financial and compliance audits of operations and activities for the purpose of determining compliance with financial and programmatic record keeping and reporting requirements of the applicable State Contract; (ii) audits of automated data processing operations to verify that systems are in place to ensure that financial and programmatic data being submitted to the State is properly safeguarded, accurate, timely, complete, reliable, and in accordance with the terms and conditions of the applicable State Contract; and (iii) program audits and reviews to measure the economy, efficiency and effectiveness of program operations under the applicable State Contract. Provider shall cooperate with Health Plan and Subcontractor in developing and implementing any necessary corrective action plans in response to audits by State or federal agencies.

3.25. **Confidentiality.** Provider shall safeguard and maintain the confidentiality of Covered Persons' medical and other records in accordance with 40 P.S. 991.2131 and all applicable State and federal laws and regulations regarding the confidentiality of patient records, as may be amended from time to time. This shall include but not be limited to compliance with the Mental Health Procedures Act (50 P.S. § 7101 et seq.), the

Confidentiality of HIV-Related Information Act (35 P.S. § 7601 et seq.), all applicable privacy rule and security rule provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and associated implementing regulations, 42 CFR 438.224 and 42 CFR Part 431, Subpart F.

3.26. **Fraud, Waste and Abuse Prevention.** Provider shall cooperate fully with Health Plan's policies and procedures designed to protect program integrity and prevent and detect potential or suspected fraud, abuse and waste in the administration and delivery of services under the State Contracts. Provider shall assist the State Programs 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.

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

3.28. **Lobbying.** Provider shall comply with the following provisions regarding lobbying:

i) Prohibition on Use of Federal Funds for Lobbying: Provider agrees, pursuant to 31 U.S.C. Section 1352 and 45 CFR Part 93, as may be amended from time to time, that no federally appropriated funds have been paid or will be paid to any person by or on Provider's behalf for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement. If the value of the Agreement exceeds $100,000, Provider agrees to complete and submit to Subcontractor and Health Plan the certification required under 31 U.S.C. Section 1352 and 45 CFR Part 93.

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

3.29. **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 employees, principals, nor any providers, subcontractors or consultants or persons with an ownership or controlling interest in the Provider (an owner including the Provider himself or herself), or an agent or managing employee of the Provider, with whom Provider

contracts and who are providing items or services that are significant and material to Provider's obligations under the Agreement is:

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

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

Provider acknowledges and agrees that payment will not be made for any items or Covered Services provided by an excluded individual pursuant to 42 CFR §1001.1901(b) and is obligated to screen all employees, contractors, and subcontractors for exclusion as required under applicable State and Federal laws. Additionally, Provider acknowledges that pursuant to 42 CFR §1003.102(a)(2) civil monetary penalties may be imposed against Provider if he or she employs or enters into contracts with excluded individuals or entities to provide items or Covered Services to Covered Persons under this Agreement. Provider agrees not to employ or subcontract with individuals or entities whose owner, those with a controlling interest, or managing employees are on a State or Federal exclusion list to provide items or Covered Services under this Agreement. Provider shall immediately report to Subcontractor and Health Plan any exclusion information discovered. 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. The GSA EPLS/SAM database can be accessed at https://www.sam.gov. Federal and State exclusion databases must be reviewed monthly to ensure that no employee or contractor has been excluded. Applicable state exclusion databases can be accessed through the State's Medicaid website. Subcontractor and/or Health Plan will terminate the Agreement immediately and exclude from its network any provider who has been terminated from the Medicare, Medicaid or CHIP program in any state. Subcontractor and/or Health Plan may also terminate the Agreement if Provider or Provider's owners, agents, or managing employees are found to be excluded on a State or Federal exclusion list.

3.30. **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 in accordance with 42 CFR 455.105. 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.

3.31. **Physician Incentive Plans.** If Provider participates in a physician incentive plan ("PIP"), Provider agrees that such PIP must comply with 42 CFR 438.6(h), 42 CFR 422.208, and 42 CFR 422.210, as may be amended from time to time. Neither 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 a Covered Person. PIPs must not contain

provisions that provide incentives, monetary or otherwise, for the withholding of Medically Necessary care. Provider must disclose annually to Health Plan and Subcontractor any PIP or risk arrangements Provider may have with physicians either within its group practice or other physicians not associated with the group practice even if there is no Substantial Financial Risk between Health Plan or Subcontractor and the physician or physician group.

3.32. **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 Subcontractor has delegated credentialing to Provider in accordance with the terms of the applicable State Contract and the contract between Subcontractor and Health Plan, Subcontractor will provide monitoring and oversight and Provider shall ensure that all licensed medical professionals are credentialed in accordance with Health Plan's and the applicable State Contract's credentialing requirements.

3.33. **Marketing.** As required under State or federal law or the applicable State Contract, any marketing materials developed and distributed by Provider as related to the performance of the Agreement must be submitted to Health Plan to submit to the applicable State Program for prior approval.

3.34. **Quality; Utilization Management.** Provider shall cooperate with and abide by Health Plan's quality management program, which includes Health Plan's quality assurance and utilization review policies and procedures, and the quality management/utilization management program requirements set forth in the applicable State Contract. In addition, hospital Providers participating in the Medical Assistance Program must comply with the following utilization management requirements related to inpatient hospital stays:

The Medical Assistance State Contract requires Health Plan's utilization management program to monitor the progress of a Covered Person's inpatient hospital stay through receipt of appropriate clinical information from the hospital within two (2) business days from the time of admission that details a Covered Person's admission information, progress to date, and any additional pertinent data. Hospital Providers shall agree to Health Plan's and/or Subcontractor's monitoring of the appropriateness of a continued inpatient stay beyond approved days according to established criteria under the direction of Health Plan's medical director and shall provide Health Plan and/or Subcontractor all necessary clinical information in a timely manner to allow for appropriate decision-making and management of care.

3.35. **False Claims.** Provider acknowledges and agrees that payments made to Provider for services provided under the Agreement are derived from federal and State funds and that any false claim or statement in documents or any concealment of material fact related to such services may be a cause for sanctions and prosecution under applicable federal and State laws. Provider shall be subject to all laws applicable to individuals and entities receiving State and federal funds and may be held civilly or criminally liable to both Health Plan and the State in the event of non-performance, misrepresentation, fraud, or abuse related to services provided pursuant to the State Contract.

3.36. **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 Subcontractor or Health Plan. A State authorized license or permit that meets the CLIA requirements may be substituted for the CLIA certificate pursuant to State law. Medicare and Medicaid programs require the applicable CLIA certification or waiver for the type of services performed as a condition of payment. Provider must include the appropriate CLIA certificate or waiver number on claims submitted for payment for laboratory services.

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

3.38. **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.

3.39. **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 Subcontractor and Health Plan any provider preventable conditions in accordance with 42 CFR §§ 434.6(a) (12), 438, including but not limited to § 438.3g, and § 447.26.

3.40. **Overpayment.** Provider shall report to Subcontractor and/or Health Plan when it has received an overpayment and will return the overpayment to Subcontractor and/or Health Plan within 60 calendar days after the date on which the overpayment was identified. Provider will notify Subcontractor and/or Health Plan in writing of the reason for the overpayment.

3.41. **Examinations to Determine Abuse or Neglect.** Upon notification by the County Children and Youth Agency system, Provider must provide Covered Persons under evaluation as possible victims of child abuse or neglect and who present for physical examinations for determination of abuse or neglect, with such services. These services must be performed by trained examiners in a timely manner according to the Child Protective Services Law, 23 Pa. C.S. §§6301 et seq. and Department regulations. Provider must ensure that emergency department staff and physicians know the procedures for reporting suspected abuse and neglect in addition to performing exams for Covered Services under the care of the county Children and Youth Agency consistent

with their obligations mandated in 18 Pa.C.S.A. §5106 and all other applicable statutes. This includes abuse or neglect of member over the age of 18 and reporting to Adult Protective Services.

3.42. **Additional Provider Assistance**. Upon United's or Subcontractor's request, Provider shall assist United or Subcontractor in its support of Covered Persons (i) by serving on interagency teams (as appropriate) and (ii) in the development of an adequate provider network to serve enrollees with chronic and complex medical conditions.

SECTION 4
ADDITIONAL REQUIREMENTS FOR AN INTEGRATED DELIVERY SYSTEM

If Provider is an Integrated Delivery System ("IDS"), as defined in 28 Pa. Code § 9.602, the following additional provisions shall apply pursuant to 28 Pa. Code §§ 9.724 and 9.725 and 31 Pa. Code § 301.314.

4.1. Provider acknowledges and agrees that under no circumstance shall provision of Covered Services to Covered Persons be delayed, reduced, denied or otherwise hindered because of the financial or contractual relationship between Health Plan or Subcontractor and Provider or between Provider and the health care providers that participate in Provider's IDS.

4.2. Provider acknowledges and agrees that only those IDS participating health care providers who meet Health Plan's credentialing and provider contracting standards may participate and provide services to Covered Persons and that the ultimate authority to approve or terminate IDS health care providers is retained by Health Plan.

4.3. Provider acknowledges and agrees that Health Plan is required to establish, operate and maintain a health care services delivery system, quality assurance system, provider credentialing system, Covered Person complaint and grievance system, and other systems meeting DOH standards and that Health Plan is directly accountable to DOH for the standards and for provision of quality, cost-effective care to Covered Persons. Nothing in the Agreement or this Appendix does or shall be construed to limit Health Plan's authority or responsibility to meet such standards or to take prompt corrective action to address a quality of care problem, resolve a Covered Person compliant or grievance, or to comply with a regulatory requirement of DOH.

4.4. Provider agrees to provide Health Plan and DOH with access to medical and other records concerning the provision of services to Covered Persons by the IDS through its participating health care providers. Provider agrees to permit and cooperate with onsite reviews by DOH for purposes of monitoring the effectiveness of Provider's performance of any Health Plan or Subcontractor delegated functions.

4.5. Provider agrees that any delegation of authority or responsibility, in part or in full, for provider credentialing and relations, quality assessment, utilization review ("UR") and other plan functions to Provider shall be subject to performance monitoring by Health Plan, Subcontractor and DOH, and subject to independent validation by Health Plan,

Subcontractor, DOH, or an independent quality review organization or Certified Utilization Review Entity ("CRE") approved by DOH.

4.6. Provider agrees to collect and provide Health Plan and Subcontractor with utilization, financial and other data for the purposes of monitoring and comparative performance analysis.

4.7. Provider shall comply with all data reporting requirements, including encounter, utilization and reimbursement methodology, required by DOH.

4.8. Provider shall obtain and maintain DOH certification as a CRE if performing UR activities as set forth in Subchapter K (relating to CREs) and sections 2151 and 2152 of Act 68 (40 P.S. §§ 991.2151 and 991.2152).

4.9. Provider agrees that the continuation of care and hold harmless provisions of this Appendix shall apply with equal force to IDS participating health care providers.

4.10. If the Agreement includes a termination without cause provision, neither Health Plan, Subcontractor nor Provider shall terminate the Agreement without cause upon less than sixty (60) days prior written notice.

4.11. Health Plan, Subcontractor and Provider agree that any delegation of medical management shall meet the requirements of 28 Pa. Code § 9.675.

4.12. Prior to the effective date of the Agreement, Health Plan will submit any required provider agreements between Provider and its IDS-participating providers for review and approval by DOH in accordance with 28 Pa. Code § 9.725. Provider agrees to cooperate with and timely provide drafts of such agreements to Health Plan to facilitate their submission to DOH. Such agreements shall be prepared to comply with the regulatory requirements of § 9.725 and, consistent with such regulation, shall at a minimum require that:

i) The IDS participating provider acknowledge and agree that nothing contained in its provider agreement limits:

a) The authority of Health Plan to ensure the IDS participating provider's participation in and compliance with Health Plan's quality assurance, utilization management, and Covered Person complaint and grievance systems and procedures or limits.

b) The authority of DOH to monitor the effectiveness of Health Plan's system and procedures or the extent to which Health Plan adequately monitors any function delegated to Provider, or to require Health Plan to take prompt corrective action regarding quality of care or Covered Person grievances and complaints.

c) Health Plan's authority to sanction or terminate an IDS participating provider found to be providing inadequate or poor quality care or failing to comply with Health Plan's systems, standards or procedures as agreed to by Provider.

ii) The IDS participating provider acknowledge and agree that any delegation by Health Plan or Subcontractor to Provider for performance of quality assurance, utilization management, credentialing, provider relations and other medical management systems shall be subject to Health Plan's oversight and monitoring of Provider's performance. An IDS participating provider must meet the minimum credentialing standards established by Health Plan and approved by the State. Health Plan retains the authority to accept, reject or terminate an IDS participating provider.

iii) The IDS participating provider acknowledge and agree that Health Plan or Subcontractor, upon failure of Provider to properly implement and administer the systems, or to take prompt corrective action after identifying quality, Covered Person satisfaction or other problems, may terminate Subcontractor's contract with Provider. As a result of such termination, an IDS participating provider's participation in Health Plan's network may also be terminated.

iv) Provider's contracts with IDS participating providers shall also contain the hold harmless and continuation of care provisions contained in this Appendix.

4.13. The following requirements shall apply if Provider's IDS has a risk-bearing Agreement with Subcontractor.

i) Provider agrees to maintain books, accounts and records as set forth in the Agreement and this Appendix and in a manner that assures that all transactions, including the risk transfer, are clearly, accurately and completely disclosed. Health Plan and Subcontractor shall have access to Provider's books, accounts and records upon terms and conditions agreed to by Health Plan, Subcontractor and Provider.

ii) Provider acknowledges and agrees that Health Plan shall have the authority to undertake such actions, and require Provider to undertake such actions, as are necessary to assure the financial viability and condition of Provider throughout the term of the Agreement. Such actions may include, but not be limited to, requiring Provider to comply with the following:

a) Securing and providing Health Plan and Subcontractor with an audited financial statement on at least an annual basis and providing Health Plan and Subcontractor with interim unaudited financial statements on a regular and ongoing basis, as determined by Health Plan.

b) Authorizing Health Plan and Subcontractor to receive information regarding Provider's reserves so as to allow Health Plan to adequately evaluate such reserves.

c) Posting a letter of credit or other acceptable financial security, in a reasonable amount as agreed upon between Health Plan, Subcontractor and Provider.

d) Subcontractor may withhold the fee, in a reasonable amount as agreed upon between Health Plan, Subcontractor and Provider, and which may be returned to Provider under the terms of the Agreement.

e) Carrying general liability insurance and requiring its participating providers to carry professional liability insurance in an amount and from a carrier mutually acceptable to Health Plan, Subcontractor and Provider.

f) Securing excess of loss insurance in an amount and from a carrier mutually acceptable to Health Plan, Subcontractor and Provider.

g) Carrying other appropriate insurance coverage, such as fidelity bonds covering Provider's employees who handle Health Plan funds, workers' compensation insurance, and a surety bond to cover Provider's performance under the Agreement.

iii) Provider shall not assign any rights or obligations under the Agreement in the absence of the express written consent of Health Plan and Subcontractor.

iv) Health Plan retains the right to be advised of, and to object to, any subcontractor of Provider performing services required to be performed by Provider under the Agreement.

v) In addition to Subcontractor's termination rights under the Agreement, Health Plan and Subcontractor shall have the right to immediately terminate the Agreement upon a valid order issued by the Commissioner of Insurance or other lawful authority.

vi) Provider shall timely advise Health Plan and Subcontractor of relevant matters that may have a material effect on Provider's ability to perform under the Agreement, including, for example, the following:

a) Whether Provider or one of its participating providers is subject to an administrative order, cease and desist order, fine or license suspension; and

b) Whether legal action has been taken which may have a material effect on Provider's financial condition or its ability to perform under the Agreement.

vii) Provider understands that Health Plan may require the implementation of an appropriate financial monitoring plan of Provider in accordance with any applicable regulatory requirements.

SECTION 5
HEALTH PLAN AND SUBCONTRACTOR REQUIREMENTS

5.1. **Prompt Payment.** Health Plan or Subcontractor shall pay Provider pursuant to the applicable State 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. 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 Health Plan or Subcontractor otherwise requests assistance from Provider, Health Plan will be

responsible for third party collections in accordance with the terms of the applicable State Contract.

5.2. **Provider Discrimination Prohibition.** Neither Health Plan nor Subcontractor shall exclude, sanction, terminate, discriminate against, or fail to renew Provider as a Participating Provider solely because:

i) Provider has a practice that includes a substantial number of patients with expensive medical conditions;

ii) Provider advocated on behalf of a Covered Person for Medically Necessary and appropriate health care services consistent with the degree of learning and skill ordinarily possessed by a reputable Health Care Provider practicing according to the applicable legal standard of care; or

iii) Provider filed a grievance on behalf of and with the written consent of a Covered Person or helped a Covered Person to file a grievance.

5.3. **Scope of License.** Neither Health Plan nor Subcontractor shall prohibit, restrict or penalize Provider, when acting within the lawful scope of Provider's license, for:

i) Discussing Medically Necessary care with, and advising or advocating appropriate medical care for or on behalf of, a Covered Person, including information regarding the nature of treatment options; risks of treatment; alternative treatments; or the availability of alternative therapies, consultations or tests that may be self-administered, even if such treatment or non-treatment options may not reflect Health Plan's or Subcontractor's position or may not be covered by the Covered Person's benefit plan; or

ii) Providing information a Covered Person needs in order to decide among all relevant treatment options and the risks, benefits, and consequences of treatment or nontreatment.

5.4. **Scope of License; Certification.** Neither Health Plan nor Subcontractor shall 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. This provision shall not be construed to prohibit Health Plan from limiting provider participation to the extent necessary to meet the needs of Covered Persons or from establishing any measure designed to maintain quality and control cost consistent with these responsibilities.

5.5. **Termination, Revocation and Sanctions.** In addition to Subcontractor's termination rights under the Agreement, Health Plan shall have the right to revoke any functions or activities Subcontractor delegates to Provider under the Agreement or impose other sanctions consistent with the applicable State Contract if in Health Plan's reasonable judgment Provider's performance under the Agreement is inadequate.

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

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

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

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

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

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

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

SECTION 6
OTHER REQUIREMENTS

6.1. **Monitoring.** Health Plan shall oversee, monitor, and remain accountable to the federal, State and city agencies with which it contracts for administration of the State Programs, and nothing in this Appendix shall limit or terminate Health Plan's duties and obligations under the State Contracts. Provider obligations and duties set forth in this Appendix are consistent with the requirements of the State Contracts and all tasks performed under the Agreement must be performed in accordance with the applicable State Contract, the applicable provisions of which are incorporated herein. If any provision of the Agreement is in conflict with provisions of the State Contracts, the terms of the applicable State Contract shall control. Nothing contained in this Appendix shall impair the rights of any federal or State agency with jurisdiction over Health Plan. Nothing contained in this Appendix shall create any contractual relationship between a Provider and any federal or state agency.

6.2. **Compliance with Medicaid Laws and Regulations.** Provider shall comply with all applicable federal and State laws, regulations and Commonwealth Management Directives, including specifically Commonwealth Management Directive No. 215.9 (Contractor's Responsibility Program), as well as any enforcement actions directly initiated by DHS, DOH or DOI pursuant to their regulatory authority over the applicable State Program. If any applicable laws or regulations are enacted, amended, promulgated, repealed, or revised, whether or not retroactively, which affect any of the rights, duties, or obligations of the parties under this Appendix, including, without limitation, the eligibility of Covered Persons or the scope of Covered Services, this Appendix shall be deemed amended accordingly effective as of the date such laws or regulations become or became effective.

6.3. **Moral or Religious Objections.** Nothing in the Agreement or this Appendix shall be construed as requiring Health Plan to provide, reimburse for, or provide coverage of, a

counseling or referral service if a Provider objects to the provision of such services on moral or religious grounds.

6.4. **No Exclusivity.** Nothing in the Agreement or this Appendix shall be construed as prohibiting or penalizing Provider for contracting with other managed care organizations or entities or as prohibiting or penalizing Health Plan or Subcontractor for contracting with other Health Care Providers.