EXHIBIT U

PROVIDER AGREEMENTS

The CHC-MCO is required to have written Provider Agreements with a sufficient number of Providers to ensure Participant access to all Medically Necessary Covered Services.

The CHC-MCO's Provider Agreements must include the following provisions:

a. A requirement that the Provider participate, as needed, in the needs screening, Assessment and Reassessment, service planning, and service coordination processes.

b. A requirement that the Provider comply with any accessibility, Cultural Competency, Linguistic Competency, and Disability Competency requirements the Department issues for meeting the needs of the CHC population.

c. A provision that the CHC-MCO may not exclude or terminate a Provider from participation in the CHC-MCO's Provider Network due to the fact that the Provider has a practice that includes a substantial number of patients with expensive medical conditions.

d. A provision that the CHC-MCO may not exclude a Provider from the CHC- MCO's Provider Network because the Provider advocated on behalf of a Participant for Medically Necessary and appropriate healthcare consistent with the degree of learning and skill ordinarily possessed by a reputable Provider practicing according to the applicable standard of care.

e. Notification of the prohibition and sanctions for submission of false Claims and statements.

f. The definition of Medically Necessary in Section II, Definitions.

g. A provision that the CHC-MCO may not prohibit or restrict a Provider acting within the lawful scope of practice from discussing Medically Necessary care and advising or advocating appropriate medical care with or on behalf of a Participant, including information regarding the nature of treatment options in order to decide among those options; the risks, benefits, and consequences of treatment and non-treatment; alternative treatments; or the availability of alternative therapies, consultation or tests that may be self-administered.

h. A provision that the CHC-MCO may not prohibit or restrict an LTSS Provider acting within the lawful scope of practice from discussing needed services and advising or advocating appropriate LTSS with or on behalf of a Participant, including information regarding the nature of LTSS options; risks; and the availability of alternative services.

i. A provision that the CHC-MCO may not terminate a contract or employment with a Provider for filing a Grievance on a Participant's behalf.

j. A provision which specifies that the agreement will not be construed as requiring the Provider to provide a counseling or referral service if the Provider objects to the provision of such services on moral or religious grounds.

k. A requirement that the Provider cooperate with the QM/UM Program standards outlined in Exhibit F, Quality Management and Utilization Management Program Requirements.

l. A requirement for cooperation for the submission of Encounter Data for all services provided within the time frames required in Section VIII, Reporting Requirements, no matter whether reimbursement for these services is made by the CHC-MCO either directly or indirectly through capitation.

m. A continuation of benefits provision which states that the Provider agrees that in the event of the CHC-MCO's insolvency or other cessation of operations, the Provider must continue to provide benefits to the CHC-MCO's Participants, including Participants in an inpatient setting, through the period for which the capitation has been paid.

n. A requirement that PCPs contact new Participants identified in the quarterly Encounter lists who have not had an Encounter during the first six (6) months of Enrollment or who have not complied with the scheduling requirements outlined in the RFP and this Agreement.

o. A requirement that should the Provider terminate its agreement with the CHC-MCO for any reason, the Provider must provide services to the Participants assigned to the Provider under the contract up to the end of the month in which the effective date of termination falls.

p. A requirement that each physician providing services to Participants must have a MMIS Provider ID Number.

q. A requirement that the Provider disclose annually any Physician Incentive Plan or risk arrangements it 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 the CHC-MCO and the physician or physician group.

r. A requirement for cooperation with the CHC-MCO's and the Department's Recipient Restriction Program.

s. A requirement that healthcare facilities and ambulatory surgical facilities 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 healthcare workers and includes effective measures for the detection, control, and prevention of Healthcare-Associated Infections.

t. A provision that the Provider must agree to the CHC-MCO's QM/UM Department's monitoring of the appropriateness of a continued inpatient stay beyond approved days according to established Medical Necessity guidelines under the direction of the CHC-MCO's Medical Director, and to provide all clinical information on the inpatient stay in a timely manner which allows for decision and appropriate management of care.

u. Language requiring the Provider to hold harmless all Participants in the event of nonpayment by the CHC-MCO for failure to obtain Prior Authorization or failure to follow any other CHC-MCO rules. Participants may not be billed or balanced billed for Covered Services.

v. Requirements regarding coordination with BH Providers (if applicable):

- Comply with all applicable statutes and regulations pertaining to the confidentiality of Participant medical records, including obtaining any required written Participant consents to disclose confidential medical records.
- Make referrals for social, vocational, education, or human services when a need for such service is identified through assessment.
- Provide health records if requested by the BH Provider.
- Notify the BH Provider of all prescriptions and, when advisable, consult with the BH Provider before prescribing medication. Make certain the BH Provider has complete, up-to-date record of medications.
- Be available to the BH Provider on a timely basis for consultations.

w. A provision that requires the Provider to comply with the procedures for reporting suspected abuse and neglect under the Older Adult Protective Services Act and the Adult Protective Services Act and for performing exams for the county.

x. Requirements that Providers follow CHC-MCO requirements for ongoing communication with Participants' Service Coordinators.

y. Requirements that Providers return Participant calls within three (3) business days of receipt.

z. A requirement that the Providers must allow for and process voluntary payroll deductions of fringe benefits or wage supplements for any employee who requests it, in accordance with the Wage Payments and Collection Law (43 P.S. §§ 260.2a and 260.3).

aa. A provision that the Provider agrees that, as required by the Department, the CHC-MCO may offset any past due amount that Provider owes to the Department against any payments due to the Provider under the Provider Agreement; provided that the Department of the CHC-MCO first provides written notice of its intention to do so.

bb. A requirement that all Nursing Facilities in the CHC-MCOs network adhere to DOH regulations.

cc. A provision that Providers in the CHC-MCOs network are prohibited from soliciting Participants to receive services from the Provider including:

- Referring an individual for CHC evaluation with the expectation that, should CHC enrollment occur, the Provider will be selected by the Participant as the service provider;
- Communicating with existing CHC Participants via telephone, face-to-face or written communication for the purpose of petitioning the Participant to change Providers;
- Communicating with hospitals, discharge planners or other institutions for the purposes of soliciting potential CHC Participants.

The CHC-MCO must make all necessary revisions to its Provider Agreements to be in compliance with the requirements set forth in this section. Revisions may be completed as Provider Agreements become due for renewal, provided that all Provider Agreements are amended within one (1) year of the effective date of this Agreement, with the exception of the Encounter Data requirements, which must be amended before the Implementation Date, if necessary, to ensure that all Providers are submitting Encounter Data to the CHC-MCO within the time frames specified in Section VIII.C.1, Encounter Data Reporting.