NEW YORK MEDICAID AND
CHILD HEALTH PLUS
REGULATORY REQUIREMENTS APPENDIX

DOWNSTREAM PROVIDER

THIS NEW YORK MEDICAID AND CHILD HEALTH PLUS REGULATORY REQUIREMENTS APPENDIX (this "Appendix") supplements and is made part of the provider agreement (the "Agreement") between OptumRx, Inc. ("Subcontractor") and the provider named in the Agreement ("Provider").

SECTION 1
APPLICABILITY

This Appendix applies with respect to the provision of health care services Provider provides directly to Covered Persons through Health Plan's (as defined herein) products or benefit plans under the State of New York Medicaid Managed Care, Medicaid Advantage and Child Health Plus programs (each a "State Program" and collectively, the "State Programs," as further defined below) as governed by the State's designated regulatory agencies. Provider has agreed to provide Covered Services to Covered Persons who receive their coverage pursuant to a contract between the State and Health Plan (the "State Contract" as defined herein). The State Contract 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 the 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 **Agreement:** An executed contract between Subcontractor and Provider for the provision of Covered Services to persons enrolled in a State Program.

2.2 **Clean Claim:** A claim that has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payments from being made on the claim.

2.3 **Covered Person:** An individual who is currently enrolled with Health Plan for the provision of services under a State Program. A Covered Person may also be referred to as an Enrollee, Member or Customer under the Agreement.

2.4 **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.

2.5 **Department or SDOH:** The New York State Department of Health.

2.6 **Health Plan:** An appropriately licensed entity that has entered into a contract with Subcontractor, either directly or indirectly, under which Subcontractor provides certain administrative services for Health Plan pursuant to the State Contract. For purposes of this Appendix, Health Plan refers to UnitedHealthcare of New York, Inc.

2.7 **Local Department of Social Services or LDSS:** A city or county social services district as constituted by Section 61 of the New York Social Services Law.

2.8 **Provider:** A hospital, ancillary provider, physician group, individual physician or other health care provider that is qualified and appropriately licensed to provide health care services to individuals enrolled in a State Program and who has entered into an Agreement or is subject to and renders Covered Services under an Agreement for such services.

2.9 **State:** The State of New York or its designated regulatory agencies.

2.10 **State Contract(s):** Health Plan's contracts with SDOH or the LDSS for the purpose of providing and paying for Covered Services to Covered Persons enrolled in a State Program.

2.11 **State Program(s):** The New York Medicaid Managed Care ("MMC"), Medicaid Advantage and Child Health Plus ("CHPlus") programs administered by the New York State Department of Health. For purposes of this Appendix, State Program may refer to the State agency(ies) responsible for administering the applicable State Program.

SECTION 3
PROVIDER REQUIREMENTS

The State Programs, through contractual requirements and federal and State statutes and regulations, require the Agreement to contain certain requirements with which Health Plan and Subcontractor must comply, including the following:

3.1 Provider shall follow the State Contracts' provisions for the coverage of Covered Services. Provider's decisions affecting the delivery of acute or chronic care services to Covered Persons shall be made on an individualized basis and in accordance with the following definitions:

(a) Emergency Medical Condition: A medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in any of the following: (1) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a pregnant woman, the health of the woman or her unborn child or, in the case of a behavioral condition, placing the health of the person or others in serious

jeopardy; (2) serious impairment to such person's bodily functions; (3) serious dysfunction of any bodily organ or part of such person; or (4) serious disfigurement of such person.

(b) Emergency Services: Covered inpatient and outpatient health care procedures, treatments or services that are furnished by a provider qualified to furnish those services and that are needed to evaluate or stabilize an Emergency Medical Condition, including psychiatric stabilization and medical detoxification from drugs or alcohol.

(c) Medically Necessary or Medical Necessity: Health care and services that are necessary to prevent, diagnose, manage or treat conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap.

3.2 Provider shall accept a woman's enrollment in Health Plan's MMC product as sufficient to provide services to her newborn, unless the newborn is excluded from participating in the MMC program or Health Plan does not offer a MMC product in the mother's county of fiscal responsibility.

3.3 Provider shall provide for timely access to Covered Person appointments in accordance with the appointment availability requirements established under the applicable State Contract, including without limitation, appointments for preventative care, urgent care, routine sick care, and well care.

3.4 Provider shall offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service beneficiaries if Provider serves only Medicaid beneficiaries.

3.5 Reserved. Family Health Plus language removed.

3.6 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.

3.7 Pursuant to N.Y. Ins. Law § 3224-a, for dates of service on or after April 1, 2010, Provider must initially submit claims within one hundred and twenty (120) days after the date of the service to be valid and enforceable against Health Plan or Subcontractor, unless a different timeframe is required by law. The requirements in this Section do not: (a) preclude Subcontractor or Provider from agreeing to a different timeframe for submission of claims provided that such timeframe is not less than ninety (90) days; or (b) supersede contract provisions in existence on April 1, 2010, except for those allowing timeframes of less than ninety (90) days for submission of claims.

3.8 In the event Health Plan or Subcontractor fails to pay Provider in accordance with the Agreement, Provider shall not seek payment from the SDOH, LDSS, Covered Persons, or persons acting on a Covered Person's behalf or eligible descendents.

3.9 Provider shall maintain appropriate records relating to services provided pursuant to the State Contracts, including, as applicable:

(a) records related to services provided to Covered Persons, including a separate medical record for each Covered Person;

(b) all financial records and statistical data that LDSS, SDOH and any other authorized governmental agency may require, including books, accounts, journals, ledgers, and all financial records relating to capitation payments, third party health insurance recovery, and other revenue received and expenses incurred under the Agreement;

(c) all documents concerning enrollment fraud or the fraudulent use of any client identification number ("CIN");

(d) all documents concerning duplicate CINs; and

(e) appropriate financial records to document fiscal activities and expenditures, including records relating to the sources and application of funds and to the capacity of Provider, if applicable, to bear the risk of potential financial losses.

Provider shall maintain all financial records and statistical data according to generally accepted accounting principles.

3.10 Provider shall preserve and retain all records relating to performance under the State Contracts in readily accessible form during the term of the Agreement and for a period of six (6) years thereafter except that Provider shall retain Covered Persons' medical records that are in the custody of Provider for six (6) years after the date of service rendered to the Covered Person or cessation of Provider's operations, and in the case of a minor, for six (6) years after majority. All provisions of this Appendix relating to record maintenance and audit access shall survive the termination of the Agreement and shall bind Provider until the expiration of a period of six (6) years commencing with termination of the Agreement or, if an audit is commenced, until the completion of the audit, whichever occurs later. If Provider becomes aware of any litigation, claim, financial management review or audit that is started before the expiration of the six (6) year period, the records shall be retained until all litigation, claims, financial management reviews or audit findings involved in the record have been resolved and final action taken.

3.11 Provider shall permit SDOH, the Comptroller of the State of New York, the New York State Attorney General, the United States Department of Health and Human Services ("DHHS"), the Comptroller General of the United States, the County Department of Social Services, or any of their authorized representatives, to access all records relating to the State Contracts for the purposes of examination, audit and copying (at reasonable cost to the requesting party) of such records. Provider shall give access to such records on two (2) business days prior written notice, during normal business hours, unless otherwise provided or permitted by applicable laws, rules, or regulations. Notwithstanding the foregoing, when records are sought in connection with a

fraud or abuse investigation, as defined respectively in 10 NYCRR § 98.1.21(a)(1) and (a)(2), all costs associated with production and reproduction shall be the responsibility of Provider.

3.12 As required under State or federal law or the applicable State Contract, any marketing materials developed and distributed by Provider in relation to the Agreement must be submitted to Subcontractor for submission to the applicable State Program(s) for prior approval.

3.13 Provider agrees to be bound by the confidentiality provisions set forth in the applicable State Contract.

3.14 Provider shall comply with all applicable privacy rule and security rule provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and associated implementing regulations, as may be amended from time to time, and shall safeguard information about Covered Persons in accordance with applicable federal and State privacy laws and rules including 42 CFR Part 431, Subpart F and 42 CFR §438.224, as may be amended from time to time.

3.15 Provider agrees that federal and State laws, regulations and guidelines pertaining to the applicable State Program(s) and Medicaid managed care organizations apply to Provider. Provider shall comply with all such laws, regulations and guidelines, including but not limited to 42 CFR 434 and 42 CFR 438.6, as may be amended from time to time and to the extent applicable to Provider in performance of the Agreement.

3.16 Provider shall cooperate fully with Subcontractor's and Health Plan's policies and procedures designed to protect program integrity and prevent and detect potential or suspected fraud, waste and abuse in the administration and delivery of services under the State Contracts. In addition, Provider shall cooperate and 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.

3.17 Provider shall comply with the following provisions regarding lobbying:

(a) Prohibition on Use of Federal Funds for Lobbying: Provider agrees, pursuant to 31 U.S.C. Section 1532 and 45 CFR Part 93, 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. Provider agrees to complete and submit to Subcontractor the "Certification Regarding Lobbying" attached to this Appendix, if the value of the Agreement exceeds $100,000.

(b) 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.

3.18 Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion. Provider certifies, by signing the Agreement, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in the Agreement by any federal department agency. If Provider is unable to certify to any of the statements in this section, Provider shall attach an explanation to the Agreement.

3.19 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 contract between Subcontractor and Health Plan, Subcontractor will provide monitoring and oversight and Provider shall assure that all licensed medical professionals are credentialed in accordance with Health Plan's and the State Contract's credentialing requirements

3.20 Provider shall comply with 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."

3.21 Provider represents that neither it nor any providers with whom it contracts (if any) is or has been sanctioned or prohibited from participation in federal health care programs under either section 1128 or section 1128A of the Social Security Act, excluded or terminated from the Medicaid program by SDOH, or had their license suspended by the New York State Education Department or the SDOH Office of Professional Medical Conduct.

3.22 Provider agrees that physician incentive plans ("PIPs") 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. If Health Plan elects to operate a PIP, Health Plan shall submit to SDOH annual reports containing information on its PIP in accordance with 42 CFR § 438.6(h). If Provider participates in a PIP under the Agreement, Provider shall submit to Subcontractor in an accurate and timely manner and in the format requested by SDOH, information on the PIP as necessary for Health Plan to comply with its reporting obligations to SDOH.

In the event that a PIP under the Agreement places the physician or physician group at risk for services beyond those provided directly by the physician or physician group for an amount beyond the risk threshold of twenty-five percent (25%) of potential payments for Covered.

Services ("Substantial Financial Risk"), Provider, Subcontractor and Health Plan must comply with all additional regulatory requirements, including but not limited to conducting Covered Person/disenrolled Covered Person satisfaction surveys, disclosing the requirements for PIPs to Covered Persons upon request, and ensuring that all physicians and physician groups at Substantial Financial Risk have adequate stop-loss protection.

SECTION 4
HEALTH PLAN AND SUBCONTRACTOR'S OBLIGATIONS

4.1 Consistent with the exception language in N.Y. Ins. Law §3224-b, Health Plan and Subcontractor shall retain the right to audit Provider's claims for a six (6) year period from the date the care, services or supplies were provided or billed, whichever is later, and to recoup any overpayments discovered as a result of the audit. This six (6) year limitation does not apply to situations in which fraud may be involved or in which Provider or an agent of Provider prevents or obstructs Health Plan's or Subcontractor's auditing. Health Plan or Subcontractor shall provide Provider an opportunity to challenge an overpayment recovery in accordance with N.Y. Ins. Law §3224-b.

4.2 In addition to the requirements found in New York Public Health Law § 4406-d, neither Health Plan nor Subcontractor shall terminate the Agreement unless Health Plan or Subcontractor provides Provider with a written explanation of the reasons for the proposed termination and an opportunity for a review or hearing. These requirements will not apply in cases involving imminent harm to patient care, a determination of fraud, or a fiscal disciplinary action by a state licensing board or other governmental agency that impairs Provider's ability to provide health care services.

(a) If Health Plan or Subcontractor intends to terminate the Agreement, the notification of the proposed termination must include:

(i) The reasons for the proposed action;

(ii) Notice that Provider has the right to request a hearing or review, at Provider's discretion, before a panel appointed by Health Plan or Subcontractor;

(iii) A time limit of not less than thirty (30) days within which Provider may request a hearing; and

(iv) A time limit for a hearing date that must be held within thirty (30) days after the receipt of a request for a hearing.

(b) Except as provided in this Section, nothing in the Agreement or this Appendix shall supersede or impair Provider's right to notice of reasons for termination and the opportunity for a hearing or review concerning such termination. The procedures for such hearing shall comply with the requirements set forth in the applicable State Contract and any applicable law. In no event shall termination be effective earlier than sixty (60) days from the receipt of the notice of termination.

4.3 Neither Health Plan nor Subcontractor shall prohibit or restrict Provider in any way from the following:

(a) Disclosing to any Covered Person, patient, designated representative or, where appropriate, prospective Covered Person any information that Provider deems appropriate regarding: (i) a condition or a course of treatment with such Covered Person, patient, designated representative or prospective Covered Person, including the availability of other therapies, consultations or tests; or (ii) the provisions, terms or requirements of Health Plan's products under the State Programs as they relate to the Covered Person, where applicable.

(b) Filing a complaint, making a report or comment to an appropriate governmental body regarding the policies or practices of Health Plan or Subcontractor when Provider believes the policies or practices negatively impact on the quality of, or access to, patient care.

(c) Advocating to Health Plan or Subcontractor on behalf of a Covered Person for approval or coverage of a particular treatment or for the provision of health care services.

4.4 In addition to Subcontractor's termination rights under the Agreement, Health Plan shall have the right to revoke any functions or activities, in whole or in part, delegated to Provider under the Agreement or impose other sanctions consistent with the applicable State Contract if Provider's performance does not satisfy the standards set forth in the applicable State Contract. In such event, Provider shall take appropriate corrective action.

SECTION 5
OTHER REQUIREMENTS

5.1 The "New York State Department of Health Standard Clauses for Managed Care Provider/IPA Contracts," (the "Standard Clauses") attached to the Agreement are expressly incorporated into the Agreement and are binding upon Health Plan, Subcontractor and Provider. In the event of any inconsistent or contrary language between the Standard Clauses and any other part of the Agreement, including but not limited to appendices, amendments and exhibits, the parties agree that the provisions of the Standard Clauses shall prevail, except to the extent the applicable State Program or applicable law requires otherwise and/or to the extent a provision of the Agreement exceeds the minimum requirements of the Standard Clauses.

5.2 All tasks performed under the Agreement shall be performed in accordance with the terms of the applicable State Contract, the applicable provisions of which are incorporated into the Agreement by reference. Health Plan shall not impose obligations and duties on Provider that are inconsistent with the State Contracts or that impair any rights accorded to LDSS, SDOH or DHHS under the State Contracts. Nothing in the Agreement shall limit or terminate Health Plan's duties and obligations under the State Contracts. If any provision of the Agreement is in conflict with provisions of the State Contracts, the terms of the State Contract shall control.

5.3 Nothing contained in the Agreement shall create a contractual relationship between Provider and the SDOH or LDSS.

5.4 Health Plan or Subcontractor, as the case may be, shall make payments to Provider for items and services covered under the State Contracts on a timely basis, consistent with the claims payment procedures described in N.Y. Ins. Law § 3224-a 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. Clean Claims submitted electronically must be paid within thirty (30) days. Clean Claims submitted by paper or facsimile must be paid within forty-five (45) days. 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 State Contracts. Unless Subcontractor otherwise requests assistance from Provider, Subcontractor will be responsible for third party collections in accordance with the terms of the applicable State Contract.

5.5 To the extent delegated to Subcontractor by Health Plan and as required under State or federal law or the State Contract, Subcontractor shall monitor Provider's performance on an ongoing basis and shall perform periodic formal reviews of Provider according to time frames established by the State, consistent with State laws and regulations, and the terms of the applicable State Contract. When deficiencies or areas for improvement are identified, Subcontractor and Provider shall take appropriate corrective action.

5.6 Either Subcontractor or Provider may exercise a right of non-renewal at the expiration of the contract period set forth in the Agreement or, for an Agreement without a specific expiration date, on each January first (1st) occurring after the Agreement has been in effect for at least one (1) year, upon sixty (60) days notice to the other party. A non-renewal shall not constitute a termination for the purposes of Section 4.2.

5.7 The Agreement shall comply with all applicable requirements of 42 CFR Part 438, as may be amended from time to time.

5.8 The parties acknowledge that the Agreement is subject to the approval of SDOH in accordance with the terms of the State Contracts and applicable State law.

5.9 Health Plan, Subcontractor and Provider shall comply with all applicable requirements of the State Public Health Law; the State Social Services Law; Title XIX of the Social security Act; Title VI of the Civil Rights Act of 1964 and 45 CFR Part 80, as amended; Title IX of the Education Amendments of 1972; Section 504 of the Rehabilitation Act of 1973 and 45 CFR Part 91, as amended; the ADA; Title XIII of the federal Public Health Services Act, 42 U.S.C. § 300e et seq. and regulations promulgated thereunder; and all other applicable legal and regulatory requirements in effect at the time the Agreement is signed and as adopted or amended during the term of the Agreement.

5.10 Any disputes between Subcontractor and Provider shall be resolved in accordance with the dispute resolution procedures set forth in the Agreement.

5.11 Unless Provider is a medical group, the Agreement shall not contain any clause purporting to transfer to Provider, by indemnification or otherwise, any liability relating to activities, actions or omissions of Health Plan or Subcontractor as opposed to those of Provider.

5.12 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 prohibit Health Plan or Subcontractor from limiting a provider's participation to the extent necessary to meet the needs of Covered Persons. This

provision also is not intended and shall not interfere with measures established by Health Plan or Subcontractor that are designed to maintain quality of care practice standards and control costs.

5.13 Neither Health Plan nor Subcontractor shall discriminate against Provider for serving high-risk Covered Persons or if Provider specializes in conditions requiring costly treatments.

CERTIFICATION REGARDING LOBBYING

The undersigned ("Provider") certifies, to the best of his or her knowledge, that:

1. No federally appropriated funds have been paid or will be paid to any person by or on behalf of Provider 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.

2. 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 this federal contract, grant, loan, or cooperative agreement, and the value of the Subcontract exceeds $100,000, Provider shall complete and submit Standard Form-LLL "Disclosure Form to Report Lobbying," in accordance with its instructions.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction pursuant to 31 U.S.C. Section 1352. The failure to file the required certification shall subject the violator to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

DATE: _____

SIGNATURE: _____

TITLE: _____

ORGANIZATION: _____

Attachment 1
New York State Department of Health
Standard Clauses for
Managed Care Provider/IPA/ACO Contracts
Revised 04/01/2017

Notwithstanding any other provision of this agreement, contract, or amendment (hereinafter "the Agreement " or "this Agreement ") the Article 44 plans and providers that contract with such plans, and who are a party agree to be bound by the following clauses which are hereby made a part of the Agreement. Further, if this Agreement is between a Managed Care Organization and an IPA/ACO, or between an IPA/ACO and an IPA/ACO, such clauses must be included in IPA/ACO contracts with Providers, and Providers must agree to such clauses.

A. Definitions for Purposes of this Appendix

"Managed Care Organization" or "MCO" shall mean the person, natural or corporate, or any groups of such persons, certified under Public Health Law Article 44, who enter into an arrangement, agreement or plan or any combination of arrangements or plans which provide or offer a comprehensive health services plan, or a health and long term care services plan.

"Independent Practice Association" or "IPA" shall mean an entity formed for the limited purpose of contracting for the delivery or provision of health services by individuals, entities and facilities licensed and/or certified to practice medicine and other health professions, and, as appropriate, ancillary medical services and equipment. Under these arrangements, such health care Providers and suppliers will provide their service in accordance with and for such compensation as may be established by a contract between such entity and one or more MCOs. "IPA" may also include, for purposes of this Agreement, a pharmacy or laboratory with the legal authority to contract with other pharmacies or laboratories to arrange for or provide services to enrollees of a New York State MCO.

"Provider" shall mean physicians, dentists, nurses, pharmacists and other health care professionals, pharmacies, hospitals and other entities engaged in the delivery of Health Care Services which are licensed, registered and/or certified as required by applicable federal and state law.

B. General Terms and Conditions

1. This agreement is subject to the approval of the New York State Department of Health (DOH) and if implemented prior to such approval, the parties agree to incorporate into this Agreement any and all modifications required by DOH for approval or, alternatively, to terminate this Agreement if so directed by DOH, effective sixty (60) days subsequent to notice, subject to Public Health Law §4403 (6)(e). This Agreement is the sole agreement between the parties regarding the arrangement established herein.

2. Any material amendment to this Agreement is subject to the prior approval of DOH, and any such amendment shall be submitted for approval in accordance with the appropriate procedures and timelines described in Sections III and VII of the New York State Department of Health Provider Contract Guidelines for MCOs and IPA/ACOs. To the extent the MCO provides and arranges for the provision of comprehensive Health Care Services to enrollees served by the Medical Assistance Program, the MCO shall notify and/or submit a copy of such material amendment to DOH, as may be required by the Medicaid Managed Care contract between the MCO and DOH.

3. Assignment of an agreement between an MCO and (1) an IPA/ACO, (2) an institutional network Provider, or (3) a medical group Provider that serves five percent or more of the enrolled population in a county, or the assignment of an agreement between an IPA/ACO and (1) an institutional Provider or (2) a medical group Provider that serves five percent or more of the enrolled population in a county, requires the prior approval of the Commissioner of Health.

4. The Provider agrees, or if the Agreement is between the MCO and an IPA/ACO or between an IPA/ACO and an IPA/ACO, the IPA/ACO agrees and shall require the IPA/ACO's Providers to agree, to comply fully and abide by the rules, policies and procedures that the MCO (a) has established or will establish to meet general or specific obligations placed on the MCO by statute, regulation, contract, or DOH or DFS guidelines or policies and (b) has provided to the Provider at least thirty days in advance of implementation, including but not limited to:

- quality improvement/management;
- utilization management, including but not limited to precertification procedures, referral process or protocols, and reporting of clinical encounter data;
- member grievances; and
- Provider credentialing.

5. The Provider or, if the Agreement is between the MCO and an IPA/ACO, or between an IPA/ACO and an IPA/ACO, the IPA/ACO agrees, and shall require its Providers to agree, to not discriminate against an enrollee based on color, race, creed, age, gender, sexual orientation, disability, place of origin, source of payment or type of illness or condition.

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

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

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

9. To the extent the MCO enrolls individuals covered by the Medical Assistance Program, this Agreement incorporates the pertinent MCO obligations under the Medicaid Managed Care

contract between the MCO and DOH as set forth fully herein, including:

a. The MCO will monitor the performance of the Provider or IPA/ACO under the Agreement and will terminate the Agreement and/or impose other sanctions if the Provider's or IPA/ACO's performance does not satisfy the standards set forth in the Medicaid Managed Care contract.

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

c. The Provider or IPA/ACO agrees to be bound by the confidentiality requirements set forth in the Medicaid Managed Care contract between the MCO and DOH.

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

e. The MCO shall not impose obligations and duties on the Provider or IPA/ACO that are inconsistent with the Medicaid Managed Care contract or that impair any rights accorded to DOH, the local Department of Social Services, or the United States Department of Health and Human Services.

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

g. The Provider or IPA/ACO agrees, pursuant to 31 U.S.C. §1352 and CFR Part 93, that no federally appropriated funds have been paid or will be paid to any person by or on behalf of the Provider/IPA/ACO 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 any Member of Congress in connection with the aware 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. The Provider or IPA/ACO agrees to complete and submit the "Certification Regarding Lobbying" Appendix, attached hereto and incorporated herein. If this Agreement exceeds $100,000. If any funds other than federally appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of a member of Congress, in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant loan, or cooperative agreement, and the Agreement exceeds $100,000 the Provider or IPA/ACO shall complete and submit Standard Form-LLL "Disclosure Form to Report Lobbying," in accordance with its instructions.

h. The Provider or IPA/ACO agrees to disclose to the MCO, on an ongoing basis,

any managing employee who has been convicted of a misdemeanor or felony in relation to the employee's involvement in any program under Medicare, Medicaid or a Title XX services program (block grant programs).

i. The Provider or IPA/ACO agrees to monitor its employees and staff against the List of Excluded Individuals and Entities (LEIE), the Social Security Administration Death Master List, and the National Plan Provider Enumeration System (NPPES).

j. The Provider or IPA/ACO agrees to disclose to the MCO complete ownership, control, and relationship information.

k. The Provider or IPA/ACO agrees to obtain for the MCO ownership information from any subcontractor with whom the Provider has had a business transaction totaling more than $25,000 during the 12-month period ending on the date of the request made by DOH, Office of the Medicaid Inspector General (OMIG) or the United States Department of Health and Human Services (DHHS). The information requested shall be provided to the MCO within 35 days of such request.

l. The Provider or IPA/ACO agrees to have an officer, director or partner of the Provider execute and deliver to DOH a certification, using a form provided by DOH through OMIG's website, within five (5) days of executing this agreement, stating that:

- The Provider or IPA/ACO is subject to the statutes, rules, regulations, and applicable Medicaid Updates of the Medicaid program and of DOH related to the furnishing of care, services or supplies provided directly by, or under the supervision of, or ordered, referred or prescribed by the Provider. This includes 18 NYCRR 515.2 except to the extent that any reference in the regulation establishing rates, fees, and claiming instructions will refer to the rates, fees and claiming instructions set by the MCO.
- All claims submitted for payment by the Provider/IPA/ACO are for care, services or medical supplies that have been provided.
- Payment requests are submitted in accordance with applicable law.

m. The Provider or IPA/ACO agrees to require that an officer, director or partner of all subcontractors if they are not natural persons, or the subcontractor itself if it is a natural person, execute a certification, using a form provided by DOH through OMIG's website, before the subcontractor requests payment under the subcontract, acknowledging that:

- The subcontractor is subject to the statutes, rules, regulations, and applicable Medicaid Updates of the Medicaid program and of DOH related to the furnishing of care, services or supplies provided directly by, or under the supervision of, or ordered, referred or prescribed by the subcontractor. This includes 18 NYCRR 515.2 except to the extent that any reference in the regulation establishing rates, fees, and claiming instructions will refer to the rates, fees and claiming instructions set by the MCO.
- All claims submitted for payment by the subcontractor are for care, services or medical supplies that have been provided.
- Payment requests are submitted in accordance with applicable law.

10. The parties to this Agreement agree to comply with all applicable requirements of the federal Americans with Disabilities Act.

11. The Provider agrees, or if the Agreement is between the MCO and an IPA/ACO or between an IPA/ACO and an IPA/ACO, the IPA/ACO agrees and shall require the IPA's Providers to agree, to comply with all applicable requirements of the Health Insurance Portability and Accountability Act, the HIV confidentiality requirements of Article 27-F of the Public Health Law, and Mental Hygiene Law § 33.13.

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

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

C. Payment and Risk Arrangements

1. Enrollee Non-liability. Provider agrees that in no event, including, but not limited to, nonpayment by the MCO or IPA/ACO, insolvency of the MCO or IPA/ACO, or breach of this Agreement, shall Provider bill; charge; collect a deposit from; seek compensation, remuneration or reimbursement from; or have any recourse against a subscriber, an enrollee or person (other than the MCO or IPA/ACO) acting on his/her/their behalf, for services provided pursuant to the subscriber contract or Medicaid Managed Care contract and this Agreement, for the period covered by the paid enrollee premium. In addition, in the case of Medicaid Managed Care, Provider agrees that, during the time an enrollee is enrolled in the MCO, Provider will not bill DOH or the City of New York for covered services within the Medicaid Managed Care benefit package as set forth in the Agreement between the MCO and DOH. This provision shall not prohibit the Provider, unless the MCO is a Managed Long Term Care plan designated as a Program of All-Inclusive Care for the Elderly (PACE), from collecting copayments, coinsurance amounts, or permitted deductibles, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for- service basis to a covered person, provided that Provider shall have advised the enrollee in writing that the service is uncovered and of the enrollee's liability therefore prior to providing the service. Where the Provider has not been given a list of services covered by the MCO, and/or Provider is uncertain as to whether a service is covered, the Provider shall make reasonable efforts to contact the MCO and obtain a coverage determination prior to advising an enrollee as to coverage and liability for payment and prior to providing the service. This provision shall survive termination of this Agreement for any reason and shall supersede any oral or written agreement now existing or hereafter entered into between Provider and enrollee or person acting on his or her behalf.

2. Coordination of Benefits (COB). To the extent otherwise permitted in this Agreement, the Provider may participate in collection of COB on behalf of the MCO, with COB collectibles accruing to the MCO or to the Provider. However, with respect to enrollees eligible for medical assistance or participating in Child Health Plus, the Provider shall maintain and make available to the MCO records reflecting COB proceeds collected by the Provider or paid directly to enrollees

by third party payers, and amounts thereof, and the MCO shall maintain or have immediate access to records concerning collection of COB proceeds.

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

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

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

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

7. The parties agree to follow Section 3224-b(a) of the Insurance Law requiring an MCO to accept and initiate the processing of all claims submitted by physicians that conform to the American Medical Association's Current Procedural Technology (CPT) codes, reporting guidelines and conventions, or to the Centers for Medicare and Medicaid Services' Healthcare Common Procedure Coding System (HCPCS).

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

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

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

11. The parties agree that for a contract involving Tier 2 or 3 arrangements as described in Section VII.B of the Guidelines, the contract must:

a. Provide for the MCO's ongoing monitoring of Provider financial capacity and/or periodic Provider financial reporting to the MCO to support the transfer of risk to the Provider; and

b. Include a provision to address circumstance where the Provider's financial condition indicates an inability to continue accepting such risk; and

c. Address MCO monitoring of the financial security deposit, describing the method and frequency of monitoring and recourse for correcting underfunding of the deposit to be maintained by the MCO; and

d. Include a provision that the Provider will submit any additional documents or information related to its financial condition to the MCO, if requested by DOH.

12. The parties agree that for any contract involving an MCO and IPA/ACO, the contract must include provisions whereby:

a. The parties expressly agree to amend or terminate the contract at the direction of DOH;

b. The IPA/ACO will submit both quarterly and annual financial statements to the MCO, as well as any additional documents required by the MCO as necessary to assess and ensure the IPA/ACO's progress towards achieving value based payment goals as specified in the Roadmap, and the MCO will notify DOH of any substantial change in the financial condition of the IPA/ACO; and

c. The IPA/ACO will submit any additional documents or information related to its financial condition to the MCO, if requested by DOH; and

d. The parties agree that all Provider contracts will contain provision prohibiting Providers, in the event of a default by the IPA/ACO, from demanding payment from the MCO for any covered services rendered to the MCO's enrollees for which payment was made by the MCO to the IPA/ACO pursuant to the risk agreement.

D. Records and Access

1. Pursuant to appropriate consent/authorization by the enrollee, the Provider will make the enrollee's medical records and other personally identifiable information (including encounter data for government-sponsored programs) available to the MCO (and IPA/ACO if applicable) for purposes including preauthorization, concurrent review, quality assurance, (including Quality Assurance Reporting Requirements (QARR)), payment processing, and qualification for government programs, including but not limited to newborn eligibility for Supplemental Security Income (SSI) and for MCO/Manager analysis and recovery of overpayments due to fraud and abuse. The Provider will also make enrollee's medical records available to the State for management audits, financial audits, program monitoring and evaluation, licensure or certification of facilities or individuals, and as otherwise required by state law. The Provider shall provide copies of such records to DOH at no cost. The Provider (or IPA/ACO if applicable) expressly acknowledges that the Provider shall also provide to the MCO and the State (at no expense to the State), on request, all financial data and reports, and information concerning the appropriateness and quality of services provided, as required by law. These provisions shall

survive termination of the contract for any reason.

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

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

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

E. Termination and Transition

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

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

3. If this Agreement is between an MCO and an IPA/ACO, and the Agreement does not provide for automatic assignment of the IPA/ACO's Provider contracts to the MCO upon termination of the MCO/IPA/ACO contract, in the event either party gives notice of termination of the Agreement, the parties agree, and the IPA/ACO's Providers agree, that the IPA/ACO Providers shall continue to provide care to the MCO's enrollees pursuant to the terms of this Agreement for 180 days following the effective date of termination, or until such time as the

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

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

5. Notwithstanding any other provision herein, to the extent that the Provider is providing Health Care Services to enrollees under the Medicaid Program, the MCO or IPA/ACO retains the option to immediately terminate the Agreement when the Provider has been terminated or suspended from the Medicaid Program.

6. In the event of termination of this Agreement, the Provider agrees, and, where applicable, the IPA/ACO agrees to require all participating Providers of its network to assist in the orderly transfer of enrollees to another Provider.

F. Arbitration

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

G. IPA/ACO-Specific Provisions

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

H. 21st Century Cures Act

Pursuant to the 21st Century Cures Act, a provider furnishing items and services to, or ordering, prescribing, referring, or certifying eligibility for, services for individuals eligible to receive Medicaid and CHP agrees to enroll in the New York State Medicaid Program by completing and filing the designated enrollment application and providing the required information necessary for enrollment. In the event that a provider is terminated from, not accepted to, or fails to submit a designated enrollment application to the NYS Medicaid Program, the provider shall be terminated from participating in any network of the MCO that serves individuals eligible to receive Medicaid or CHP.