REQUIRED PROVISIONS TO NETWORK PROVIDER AGREEMENTS

In this chapter, you will find mandatory contract language required by the State of New York and the Centers for Medicare & Medicaid Services, including the Managed Care Law of 2009, the NYSDOH Standard Clauses, the Special Provisions Related to Medicaid Members and the Medicare Advantage Addendum.

- **Managed Care Law of 2009**
- **Medicare Advantage/Medicare-Medicaid Required Provisions**
- **NYSDOH Standard Clauses for Managed Care Provider/IPA Contracts Appendix Effective: April 1, 2017**
- **Provision Related to Medicaid, Managed Long Term Care and Family Health Plus Members**
- **Special Provisions Related to Medicaid, CHP & HARP Members**
- **Medicare Advantage Addendum**

MANAGED CARE LAW OF 2009

Chapter 237 of the Laws of 2009 amended statutes related to claims processing and managed care organization procedures regarding credentialing, utilization review and external appeals as well as reimbursement arrangements in provider contracts. All network practitioners, providers, and facilities (individually or collectively referred to as Provider) contracted with GHI HMO Select Inc., Group Health Incorporated, HIP Health Plan of New York, and HIP Network Services IPA (individually or collectively referred to as Plan), agree to be bound by the following clauses, as applicable to them, which are a part of and incorporated into the Agreements.

1. **Provisional Credentialing (Applicable only to providers joining group practice in New York.):** This law provides that Plan has procedures regarding provisional credentialing. Plan's policies, procedures and Provider Manual have been updated to reflect this new plan participation status. Plan permits provisional credentialing to take effect prior to completion of the full 90-day credentialing process. This provisional status is available only to Providers who are newly licensed or recently relocated and who join a group practice that already participates with Plan's HMO networks. If a provisional credentialing application is denied, Plan will consider any work performed by that Provider to be an out-of-network service, and the Provider (or their group practice) shall repay the Plan the difference between the in- and out-of-network fees as stipulated under each member's benefit plan. Under no circumstances may the Provider (or group practice) attempt to recover this difference from the Member, except to collect copayment or coinsurance that would otherwise be payable had the Member received Covered Services from a health care professional in the Plan network.

2. **Adverse Reimbursement Change (Applicable only to health care professionals licensed, registered or certified pursuant to Title Eight of the New York State Education Law.):** Plan may amend its Agreements with network clinicians upon thirty (30) days written notice to network health care professionals for: (i) non-fee schedule changes; (ii) non-adverse fee schedule changes; (iii) adverse fee schedule changes that are the result of a Regulatory Change, and (iv) adverse fee schedule changes that are the result of changes to fee schedules or payment policies established by government agencies; or changes to CPT codes or contractual references to a specific fee schedule, reimbursement methodology or indexing mechanism. The amendment will become effective upon the expiration of the thirty (30) day notice period without action by the clinician. If the clinician objects to the amendment, the clinician may terminate his/her agreement upon sixty (60) days written notice to Plan; however the amendment shall be in full force and effect during the termination notice period.

3. Except for those adverse reimbursement schedule changes noted above, Plan may amend the fee schedule for network clinicians upon ninety (90) days written notice for all adverse reimbursement schedule changes. The amendment will become effective upon the expiration of the ninety (90) day notice period without action on the part of the clinician. If the clinician objects to the adverse fee schedule amendment, the clinician may terminate this agreement upon thirty (30) days written notice to Plan. The fee schedule reimbursement amendment will not be implemented during the termination notice period.

4. **Claims Processing Time Frames:** Plan must pay claims submitted electronically within 30 days. Paper or facsimile claim submissions must be paid by Plan within 45 days. The 30-day time frame for requesting additional information or for denying the claim was not changed. Plan shall comply with the timeframe for payment of claims specified in the New York Insurance Law Section 3224-a.

5. **Coordination of Benefits (COB):** Plan may not deny a claim because it is coordinating benefits with another insurer unless it has a reasonable basis to believe that the member has other primary health insurance coverage for the claimed benefit. If a member does not provide the Plan with COB information within 45 days of its request, the Plan will adjudicate the claim. The Plan will not deny a claim on the basis of non-receipt of information about other coverage.

6. **Overpayment Recovery:** The process for overpayment recoveries now applies to licensed facilities as well as health care professionals. For further information on overpayment recovery requirements, please refer to the Provider Manual at **www.emblemhealth.com**.

7. **Claims from a Network Hospital Associated with an Out-of-Network Health Care Provider Claim and Claims from a Network Health Care Provider Associated with an Out-of-Network Hospital Claim:** Plan will not treat a claim from a network hospital as out of network solely on the basis that an out-of-network health care provider treated the member. Likewise, a claim from a network health care provider will not be treated as out of network solely because the hospital is out of network with Plan.

8. **Rare Disease Treatment:** Denials of rare disease treatment as defined in PHL § 4900(7-g) are now subject to the Plan's utilization review policies and procedures and are eligible for external appeal rights.

9. **Home Health Care Determinations:** The timeframe for utilization review determinations of home health care services following an inpatient hospital admission was changed. The Plan will provide Provider with notice of its determination within one (1) business day of receipt of the necessary information or, if the day after the request for services falls on a weekend or

holiday, within 72 hours of receipt of necessary information. If a request for home health care services and all necessary information is provided to Plan prior to a Member's inpatient hospital discharge, Plan will not deny the home care coverage request on the basis of a lack of medical necessity or a lack of prior authorization while the review determination is pending. There may, however, be other reasons for denying the service such as the exhaustion of a benefit. Denials for home health services following a discharge from a hospital admission will be treated as expedited appeals.

10. **External Appeal Rights of Concurrent Denials:** The law establishes rules to determine who must pay for an external appeal of a concurrent denial. The party responsible for the cost of the external appeal depends in large part on the external appeal agent's determination.
11. **Alternative Dispute Resolution:** An Article 28 facility may agree to an alternative dispute resolution in lieu of an external appeal. The alternative dispute process does not affect a Member's external appeal rights or the Member's right to establish the Provider as his/her designee.
12. **Hold Harmless:** Provider (acting for himself/herself or as a Member's designee) requesting an external appeal of a concurrent adverse determination, is prohibited from seeking payment, except applicable copays, from a Member for services deemed not medically necessary by the external appeal agent.
13. **Time Frame for Provider Claims Submission:** Unless the Provider's contract provides for a greater period of time, or is otherwise provided by law, providers now have 120 days after the date of the service to submit claims to Plan and, for COB claims, ninety (90) days from the date the Explanation of Benefits was issued by the primary payor. Insurance Law 3224-a was amended with two new provisions related to the time period for submission of claims. New subsection (g) states that providers must initially submit claims within 120 days after the date of the service to be valid and enforceable unless a time frame more favorable to the provider was agreed to by the provider and the plan or a different time frame is required by law. The Plan will reconsider a network provider's late claim if Provider can demonstrate that the late claim resulted from an unusual occurrence and Provider has a pattern of timely claims submissions. The Plan may reduce the reimbursement of a claim by up to 25 percent of the amount that would have been paid had the claim been submitted in a timely manner. The right to reconsideration shall not apply to a claim submitted 365 days after the service. In such cases, the Plan may deny the claim in full.

New York State Department of Health

Standard Clauses for Managed Care Provider/IPA/ACO Contracts

APPENDIX
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 award of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement. 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 and Family Health Plus programs, the overpayment recovery period for such programs is six years from date payment was received by the health care Provider with written notice 30 days prior to engaging in overpayment recovery efforts. Such notice must state the patient's name, service date, payment amount, proposed adjustment, and a reasonably specific explanation of the proposed adjustment.

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 (applies to Tier 1, Tier 2, and Tier 3);
    b. The IPA/ACO will submit annual financial statements to the MCO, as well as any additional documents required by the MCO as necessary to assess the IPA/ACO's progress towards achieving value based payment goals as specified in the Roadmap, and the MCO will notify DOH of any substantial change in the financial condition of the IPA/ACO (applies to Tier 2 and Tier 3); and
    c. The IPA/ACO will submit any additional documents or information related to its financial condition to the MCO, if requested by DOH (applies to Tier 2 and Tier 3); and
    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 (applies to Tier 2 and Tier 3).

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.

PROVISION RELATED TO MEDICAID, MANAGED LONG TERM CARE AND FAMILY HEALTH PLUS MEMBERS

The following provision applies to health care services rendered by Provider to: (i) Medicaid Managed Care, (ii) Family Health Plus (FHPlus) and (iii) Managed Long Term Care (MLTC) members covered under a Benefit Plan pursuant to the Plan's contracts with the New York State Department of Health.

a. Participating Providers who wish to let their patients know of their affiliations with one or more Managed Care Organizations (MCOs) must list each MCO with whom they have contracts.

b. Participating Providers who wish to communicate with their patients about managed care options must advise patients, taking into consideration ONLY the managed care options that best meet the health needs of the patients. Such advice, whether presented verbally or in writing, must be individually based and not merely a promotion of one MCO over another.

c. Participating Providers may display the Plan's outreach materials provided that appropriate material is conspicuously posted for all other MCOs with whom the Participating Provider has a contract.

d. Upon termination of a Provider Agreement with the Plan, a Provider who has contracts with other MCOs that offer Medicaid, FHPlus or MLTC products may notify their patients of the change in status and the impact of such change on the patient.

MEDICARE ADVANTAGE
MEDICARE/MEDICAID DUAL ELIGIBLE

ADDENDUM

Medicare Advantage/Medicare-Medicaid Required Provisions

The Plan has a contract with CMS for the provision of services to Medicare Enrollees. Accordingly, Practitioner agrees to provide all services under the Agreement in compliance with the following provisions.

Definitions:

Centers for Medicare and Medicaid Services ("CMS"): the agency within the Department of Health and Human Services that administers the Medicare program.

Completion of Audit: completion of audit by the Department of Health and Human Services, the Government Accountability Office, or their designees of a Medicare Advantage Organization, Medicare Advantage Organization contractor or related entity.

Downstream Entity: any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the Medicare Advantage benefit, below the level of the arrangement between an Medicare Advantage organization (or applicant) and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

Final Contract Period: the final term of the contract between CMS and the Medicare Advantage Organization.

First Tier Entity: any party that enters into a written arrangement, acceptable to CMS, with an Medicare Advantage organization or applicant to provide administrative services or health care services for a Medicare eligible individual under the Medicare Advantage program.

Medicare Advantage ("MA"): an alternative to the traditional Medicare program in which private plans run by health insurance companies provide health care benefits that eligible beneficiaries would otherwise receive directly from the Medicare program.

Medicare Advantage Organization ("MA organization"): a public or private entity organized and licensed by a State as a risk-bearing entity (with the exception of provider-sponsored organizations receiving waivers) that is certified by CMS as meeting the Medicare Advantage contract requirements.

Member or Enrollee: a Medicare Advantage eligible individual who has enrolled in or elected coverage through a Medicare Advantage Organization.

Provider: (1) any individual who is engaged in the delivery of health care services in a State and is licensed or certified by the State to engage in that activity in the State; and (2) any entity that is engaged in the delivery of health care services in a State and is licensed or certified to deliver those services if such licensing or certification is required by State law or regulation.

Related entity: any entity that is related to the Medicare Advantage organization by common ownership or control and (1) performs some of the Medicare Advantage organization's management functions under contract or delegation; (2) furnishes services to Medicare enrollees under an oral or written agreement; or (3) leases real property or sells materials to the Medicare Advantage organization at a cost of more than $2,500 during a contract period.

Required Provisions:

Practitioner agrees to the following:

1. HHS, the Comptroller General or their designees have the right to audit, evaluate and inspect any pertinent information for any particular contract period, including, but not limited to, any books, contracts, computer or other electronic systems (including medical records and documentation of the first tier, downstream and entities related to CMS' contract with Plan (hereinafter, "MA organization") through 10 years from the final date of the final contract period of the contract entered into between CMS and the MA organization or from the date of completion of any audit, whichever is later. [42 C.F.R. §§ 422.504(i)(2)(i) and (ii)]

2. Practitioner will comply with the confidentiality and enrollee record accuracy requirements, including: (1) abiding by all Federal and State laws regarding confidentiality and disclosure of medical records, or other health and enrollment information; (2) ensuring that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas; (3) maintaining the records and information in an accurate and timely manner; and (4) ensuring timely access by enrollees to the records and information that pertain to them. [42 C.F.R. §§ 422.504(a)(13) and 422.118]

3. Enrollees will not be held liable for payment of any fees that are the legal obligation of the MA organization. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)]

4. For all enrollees eligible for both Medicare and Medicaid, enrollees will not be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts. Providers will be informed of Medicare and Medicaid benefits and rules for enrollees eligible for Medicare and Medicaid. Practitioner may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under title XIX if the individual were not enrolled in such a plan. Providers will: (1) accept the MA plan payment as payment in full; or (2) bill the appropriate State source. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)]

5. Any services or other activity performed in accordance with a contract or written agreement by Practitioner are consistent and comply with the MA organization's contractual obligations. [42 C.F.R. § 422.504(i)(3)(iii)]

6. Contracts or other written agreements between the MA organization and providers or between first tier and downstream entities must contain a prompt payment provision, the terms of which are developed and agreed to by the contracting parties. The MA organization is obligated to pay contracted providers under the terms of the contract between the Practitioner and the Provider. [42 C.F.R. §§ 422.520(b)(1) and (2)]

7. Practitioner and any related entity, contractor or subcontractor will comply with all applicable Medicare laws, regulations and CMS instructions. [42 C.F.R. §§ 422.504(i)(4)(v)]

8. If any of the MA organization's activities or responsibilities under its contract with CMS are delegated to any first tier, downstream and related entity:

   i. The delegated activities and reporting responsibilities are specified in writing**.**

   ii. CMS and the MA organization reserve the right to revoke the delegation activities and reporting requirements or to specify other remedies in instances where CMS or the MA organization determine that such parties have not performed satisfactorily.

   iii. The MA organization will monitor the performance of the parties on an ongoing basis.

   iv. The credentials of medical professionals affiliated with the party or parties will be either reviewed by the MA organization or the credentialing process will be reviewed and approved by the MA organization and the MA organization must audit the credentialing process on an ongoing basis.

   v. If the MA organization delegates the selection of providers, contractors or subcontractor, the MA organization retains the right to approve, suspend or terminate any such arrangement. [42 C.F.R. §§ 422.504(i)(4) and (5)].

In the event of a conflict between the terms and conditions above and the terms of a related agreement, the terms above control.

Medicare-Medicaid Program Required Provisions

The Plan has a contract with CMS for the provision of services under the Medicare-Medicaid ("MMP") Program. Accordingly, Practitioner agrees to provide all services under the Agreement in compliance with the following provisions.

1. HHS, the Comptroller General or their designees have the right to audit, evaluate and inspect any pertinent information of Practitioner including books, contracts, records, including medical records, and documentation related to CMS' contract with the Plan for a period of 10 years from the final date of the contract period or the completion of any audit, whichever is later. §422.504(i)(2)(i) and (ii).

2. Where applicable, Practitioner providers and suppliers agree to safeguard beneficiary privacy and confidentiality of beneficiary health records. §422.504(a)13.

3. Where applicable, Practitioner may not hold beneficiaries liable for payment of fees that are the legal obligation of the Plan. §422.504(g)(1)(i); §422.504(i)(3)(i).

4. Any services performed will be consistent and comply with the Plan's contractual obligations with CMS and New York State Department of Health. §422.504(i)(3)(iii).

5. The Plan retains the right to approve, suspend or terminate such arrangement. §422.504(i)(5).

6. All delegated activities and reporting responsibilities of Practitioner are clearly defined in this Agreement. §422.504(i)(4)(i).

7. The Plan may revoke any of the delegated activities and reporting requirements or specify other remedies in instances when CMS or the New York State Department of Health determines that the parties to this Agreement have not performed satisfactorily. §422.504(i)(3)(ii); §422.504(i)(4)(ii).

8. Performance of the parties is monitored by the Plan on an ongoing basis. §422.504(i)(3)(ii); §422.504(i)(4)(iii).

9. The credentials of medical professionals affiliated with the parties will either be reviewed by the Plan or the credentialing process will be reviewed and approved by the Plan; and the Plan must audit the credentialing process on an ongoing basis. §422.504(i)(4)(iv)(A)(B).

10. Practitioner must comply with all applicable Medicare laws, regulations and CMS instructions. §422.504(i)(4)(v).

11. This Agreement incorporates the Medicare-Medicaid population.

12. Practitioner will complete required FIDA training outlined in the New York State Memorandum of Understanding or certify to HIP or the Plan that training has been completed through another health plan or organization approved by CMS to provide such training. Training will include:

    i. No balance billing of FIDA participants.
    ii. Cultural and linguistic competency for delivering services to FIDA participants.
    iii. Physical accessibility, which is defined in accordance with US Department of Justice ADA guidance for providers.
    iv. Disability competency for delivering services to FIDA participants.

    Required training for Interdisciplinary Care Team Members (IDT) only:

    i. Person-centered planning process
    ii. Independent living and recovery
    iii. Wellness principles
    iv. Olmstead requirements
    v. Coordinating with behavioral health and community-based and facility-based long-term services and supports (LTSS) providers, providing information about accessing behavioral health and community-based and facility-based LTSS, and furnishing lists of community supports available.
    vi. How to identify behavioral health needs, how to assist the Participant in obtaining behavioral health services, how to identify community-based and facility-based LTSS needs, and how to assist the Participant in obtaining community-based and facility-based LTSS services (required only for primary care providers)

13. Practitioner agrees to use evidence-based practices specific to his/her/their area of practice.