MOLINA HEALTHCARE OF NEW YORK, INC.
PROVIDER SERVICES AGREEMENT

SIGNATURE PAGE

In consideration of the promises, covenants, and warranties stated, the Parties agree as set forth in this Agreement. The Authorized Representative acknowledges, warrants, and represents that the Authorized Representative has the authority and authorization to act on behalf of its Party. The Authorized Representative further acknowledges he/she received and reviewed this Agreement in its entirety.

The Authorized Representative of Provider acknowledges the Provider Manual was available for review prior to entering into this Agreement, and agrees that Provider will comply with the provisions set forth under the Provider Manual section and other applicable provisions related to the Provider Manual in the Agreement.

The Authorized Representative for each Party executes this Agreement with the intent to bind the Parties in accordance with this Agreement.

Effective Date of Agreement ("Effective Date"): 05/01/2024

Provider Signature and Information:

Provider's Legal Name ("Provider") – Matching the applicable tax form (i.e. W-9, Line 1): Mind Orientation Applied Behavior Analysis	
Authorized Representative's Signature: DocuSigned by: 6A7ABD7018124A5...	Authorized Representative's Name – Printed: Zlaty Kahan
Authorized Representative's Title: Owner	Authorized Representative's Signature Date: 12/29/2023
Telephone Number: 347-675-6102	Fax Number – Official Correspondence:
Mailing Address – Official Correspondence: 4205 17th Avenue, Unit #3, Brooklyn, NY, 11204	Payment Address – If different than Mailing Address: 4205 17th Avenue, Unit #3, Brooklyn, NY, 11204
IRS 1099 Address – If different than Mailing Address:	Tax ID Number – As listed on corresponding tax form: 86-2193128
NPI – That corresponds to the above Tax ID Number: 1841868940	Email Address – Official Correspondence: info@mindorientation.com

Health Plan Signature and Information:

Molina Healthcare of New York, Inc., a New York Corporation ("Health Plan")	
Authorized Representative's Signature:	Authorized Representative's Name – Printed: Mary Shinham
Authorized Representative's Title: Plan President	Authorized Representative's Countersignature Date: 3/1/2024
Mailing Address – Official Correspondence: 1776 Eastchester Road, Bronx, NY-10461	Email Address – Official Correspondence: mary.shinham@molinahealthcare.com

PROVIDER SERVICES AGREEMENT

Health Plan and Provider enter into this Agreement as of the Effective Date set forth on the Signature Page of this Agreement. The Provider and Health Plan each are referred to as a "Party" and collectively as the "Parties".

RECITALS

A. WHEREAS, Health Plan is a corporation licensed and approved by required agencies to operate a health care service plan, including without limitation, to issue benefit agreements covering the provision of health care and related services and enter into agreements with Participating Providers;

B. WHEREAS, Provider is approved to provide health care or related services and desires to provide services to eligible recipients; and

C. WHEREAS, the Parties intend by entering into this Agreement they will make health care or related services available to eligible recipients enrolled in various Products covered under this Agreement.

NOW, THEREFORE, in consideration of the promises, covenants, and warranties stated herein, the Parties agree as follows:

ARTICLE ONE – DEFINITIONS

1.1 Capitalized words or phrases in this Agreement have the meaning set forth below.

a. **Advance Directive** means a Member's written instructions, recognized under Law, relating to the provision of health care, when the Member is not competent to make a health care decision as determined under Law.

b. **Affiliate** means an entity owned or controlled by Health Plan or Molina Healthcare, Inc. which can be found on MolinaHealthcare.com.

c. **Agreement** means this Provider Services Agreement between Provider and Health Plan and all attachments, exhibits, addenda, amendments, and incorporated documents or materials.

d. **Centers for Medicare and Medicaid Services ("CMS")** means the agency responsible for Medicare, and certain parts of Medicaid, CHP, Medicare-Medicaid Program, and the Health Insurance Marketplace.

e. **Child Health Plus ("CHP")** means the program established pursuant to Title XXI of the Social Security Act, as amended.

f. **Claim** means a bill for Covered Services provided by Provider.

g. **Clean Claim** means a Claim for Covered Services submitted on an industry standard form, which has no defect, impropriety, lack of required substantiating documentation, or particular circumstance requiring special treatment that prevents timely adjudication of the Claim.

h. **Covered Services** mean those health care services and supplies, including Emergency Services, provided to Members that are Medically Necessary and are benefits of a Member's Product.

i. **Cultural Competency Plan** means a plan that ensures Members receive Covered Services in a manner that takes into account, but is not limited to, developmental disabilities, physical disabilities, differential abilities, cultural and ethnic backgrounds, and limited English proficiency.

j. **Date of Service** means the date on which Provider provides Covered Services or, for inpatient services, the date the Member is discharged.

k. **Downstream Entity** means any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the Medicare Advantage, Medicaid, or MMP Product, below the level of the arrangement between Health Plan (or applicant) and Provider. These written arrangements continue down to the level of the ultimate provider for health and administrative services.

l. **Emergency Services** mean the definition as defined in the applicable Government Contract. If there is no applicable Government Contract, it means all covered inpatient and outpatient services furnished by a provider

who is qualified to furnish these services and such services are needed to evaluate or stabilize an emergency medical condition.

m. **Encounter Data** means all data captured during the course of a single health care encounter that specifies: (i) the diagnoses, comorbidities, procedures (therapeutic, rehabilitative, maintenance, or palliative) pharmaceuticals, medical devices, and equipment associated with a Member receiving services during the encounter; (ii) the identification of the Member receiving and the provider providing the health care services during the single encounter; and (iii) a unique and unduplicated identifier for the single encounter.

n. **Essential Plan** means the Basic Health Program offered by the State of New York under Title I of the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), referred to collectively as the Affordable Care Act, including all implementing statutes and regulations.

o. **Government Contracts** mean those contracts between Health Plan and state and federal agencies for the arrangement of health care and related services for an applicable Government Program.

p. **Government Programs** mean various government sponsored health products in which Health Plan participates. The Government Programs that are Products under this Agreement are identified in Attachment A.

q. **Government Program Requirements** mean the requirements of governmental agencies for a Government Program, which includes, but is not limited to, the requirements set forth in the Government Contract.

r. **Grievance Program** means the procedures established by Health Plan to timely address Member and Provider complaints or grievances.

s. **Health Insurance Marketplace** means those health insurance products/programs required by Title I of the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), referred to collectively as the Affordable Care Act, including all implementing statutes and regulations.

t. **Health Plan** means Molina Healthcare of New York, Inc., a New York Corporation.

u. **Law** means all statutes, codes, and regulations applicable to this Agreement.

v. **Medicaid** means the joint federal-state program provided for under Title XIX of the Social Security Act, as amended.

w. **Medically Necessary or Medical Necessity** means the definition as defined in the Applicable Government Contract. If there is no applicable Government Contract, it means health care services provided to a patient for the purpose of evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms and that are: (i) in accordance with generally accepted standards of medical practice; (ii) appropriate for the symptoms, diagnosis, or treatment of the Member's condition, disease, illness or injury; (iii) not primarily for the convenience of the Member or health care provider; and (iv) not more costly than an alternative service, or site of services, at least as likely to produce equivalent results.

x. **Medicare Advantage ("MA")** means a program in which private health plans provide health care and related services through a Government Contract with CMS, which is authorized under Title XVIII of the Social Security Act, as amended (otherwise known as "Medicare"). Medicare Advantage also includes Medicare Advantage Special Needs Plans ("MA-SNP").

y. **Medicare-Medicaid Program ("MMP")** means a program in which private health plans provide health care and related services to beneficiaries eligible for both Medicaid and Medicare through a Government Contract with CMS and the State.

z. **Member** means a person enrolled in a Product and who is eligible to receive Covered Services.

aa. **Molina Marketplace** means the Products offered and sold by Health Plan under the requirements of the Health Insurance Marketplace.

bb. **Overpayments** mean a payment Provider receives, which after applicable reconciliation, Provider is not entitled to receive pursuant to Laws, Government Program Requirements, or this Agreement.

cc. **Participating Provider** means a healthcare facility or practitioner contracted with and, as applicable, credentialed by Health Plan or Health Plan's designee.

dd. **Product** means the various health insurance programs offered by Health Plan to Members in which Provider agrees to be a Participating Provider, identified on Attachment A, Products, and which will include any successors to such Products.

ee. **Provider** means the entity identified on the Signature Page of this Agreement and includes any person or entity performing Covered Services on behalf of Provider and for which: (i) an entity of the Provider bills under an owned tax identification number; and (ii), when applicable, such person or entity has been approved by Health Plan as a Participating Provider. Each entity or person shall be considered an "Individual Provider".

ff. **Provider Manual** means Health Plan's provider manuals, policies, procedures, documents, educational materials, and, as applicable, Supplemental Materials, setting forth Health Plan's requirements and rules that Provider is required to follow.

gg. **Quality Improvement Program ("QI Program")** means the policies and procedures, interventions, and systems, developed by Health Plan for monitoring, assessing, and improving the accessibility, quality, and continuity of care provided to Members.

hh. **Responsible Entity** means an entity that is financially responsible for certain Covered Services and pays Claims that are part of its financial responsibility.

ii. **Subcontractor** means an individual or organization, including Downstream Entity, with which Provider contracts for the provision of Covered Services or administrative functions related to the performance of this Agreement. For the avoidance of doubt, a Subcontractor does not include Individual Providers.

jj. **Utilization Review and Management Program ("UM Program")** means the policies, procedures, and systems developed by Health Plan for evaluating and monitoring the Medical Necessity, appropriateness, efficacy, or efficiency of core health care benefits and services, procedures or settings and ambulatory review, prospective review, concurrent review, second opinions, care management, discharge planning, or retrospective reviews, including, but not limited to, under-utilization and over-utilization.

ARTICLE TWO – PROVIDER OBLIGATIONS

2.1 **Provider Standards.**

a. **Standard of Care.** Provider agrees to provide Covered Services within the scope of Provider's business. Provider will ensure all services and interactions with Members are at a level of care and competence that equals or exceeds generally accepted and professionally recognized standards of practice, rules, and standards of professional conduct, Laws and Government Program Requirements.

b. **Facilities, Equipment, and Personnel.** Provider's facilities, equipment, personnel, and administrative services will be at a level and quality necessary to perform Provider's duties and responsibilities under this Agreement and to comply with Laws and Government Program Requirements.

c. **Prior Authorization.** For Covered Services that require prior authorizations, Provider will obtain prior authorization from Health Plan before providing such Covered Service. Provider will not have to obtain prior authorizations before providing Emergency Services.

d. **Use of Participating Providers.** Except in the case of Emergency Services or when Provider obtains prior authorization, Provider will only utilize Participating Providers to provide Covered Services. If a Participating Provider is not available, Provider will notify Health Plan so Health Plan can determine the appropriate provider to perform such services.

e. **Prescriptions.** When prescribing medications that a Member gets through a pharmacy, Provider will follow Health Plan's Drug Formulary/Prescription Drug List, and prior authorization and prescription policies. Provider

acknowledges the authority of pharmacies to substitute generics or low cost alternative prescriptions for the prescribed medication.

f. **Provider-Member Communication.** Health Plan encourages open Provider-Member communication regarding Medical Necessity, appropriate treatment, and care. Provider is free to communicate all treatment options to Members regardless of limitations on Covered Services.

g. **Member Eligibility Verification.** Provider will verify eligibility of Members before providing services unless the situation involves the provision of Emergency Services.

h. **Availability of Services.** Provider will make necessary and appropriate arrangements to assure availability of Covered Services twenty-four (24) hours a day, seven (7) days a week. Provider will meet applicable standards for timely access to care and service in accordance with Laws and Government Program Requirements.

i. **Hospital Admission Notifications.** Provider will immediately notify Health Plan of Member hospital admissions, including inpatient admissions and Members referred to the emergency department.

j. **Staffing Privileges for Providers.** Provider will have staff privileges with at least one (1) Health Plan contracted hospital as necessary to provide Covered Services. Provider will authorize each hospital to notify Health Plan if disciplinary or other action of any kind is initiated against Provider, which could result in the suspension, reduction, or modification of Provider's hospital privileges. If Provider does not have staff privileges with at least one (1) Health Plan contracted hospital, Provider must provide an acceptable arrangement to Health Plan that ensures Member continuity of care.

2.2 **Rights of Members.** Provider will observe, protect, and promote the rights of Members.

2.3 **Use of Name.** Provider will display Health Plan's promotional materials as practical and will cooperate in reasonable Health Plan marketing efforts that do not violate Laws or Government Program Requirements. Provider will not use Health Plan's name in advertising or promotional materials without the prior written consent of Health Plan. Health Plan may use Provider's name and related information in: (i) publications to identify Provider as a Participating Provider; and (ii) as may be required to comply with the Laws and Government Program Requirements.

2.4 **Non-Discrimination in Enrollment.** Provider will not differentiate or discriminate in providing Covered Services because of race, color, religion, national origin, ancestry, age, sex, marital status, sexual orientation, physical, sensory or mental handicap, socioeconomic status, or participation in publicly financed programs of health care services. Provider will provide Covered Services in the same location, in the same manner, in accordance with the same standards, and within the same time or availability, regardless of payer.

2.5 **Recordkeeping.**

a. **Maintaining Member Record.** Provider will maintain a medical and billing record ("Record") for each Member to whom Provider provides health care services. The Member's Record will contain all information required by Laws, generally accepted and prevailing professional practices, applicable Government Program Requirements, and Health Plan's policies and procedures. Provider will retain such Record for as long as required by Laws and Government Program Requirements. This section will survive any termination.

b. **Confidentiality of Member Record.** Provider will comply with all Laws, including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Health Information Technology for Economic and Clinical Health ("HITECH") Act, Health Plan's policies and procedures, and Government Program Requirements regarding privacy and confidentiality. Provider will not disclose or use Member names, addresses, social security numbers, identities, other personal information, treatment modalities, or Record without obtaining appropriate authorization. This section does not affect or limit Provider's obligation to make available the Record, Encounter Data, and information concerning Member care to Health Plan, a state or federal agency, or another provider of health care. This section will survive any termination.

c. **Delivery of Member Information.** Provider will promptly deliver to Health Plan, upon request or as may be required by Laws, Health Plan's policies and procedures, Government Program Requirements, or third party payers, any information, statistical data, Encounter Data, or Record pertaining to a Member. Provider is

responsible for the fees associated with producing the above items. Provider will further give direct access to the items as requested by Health Plan or as required by a state or federal agency. Health Plan has the right to withhold compensation from Provider if Provider fails or refuses to give the items to Health Plan promptly. This section will survive any termination.

d. **Member Access to Member Record.** Provider will give Members access to Members' Record and other applicable information, in accordance with Laws, Government Program Requirements, and Health Plan's policies and procedures. This section will survive any termination.

2.6 **Program Participation.**

a. **Participation in Grievance Program.** Provider will participate in and comply with Health Plan's Grievance Program, and will cooperate with Health Plan in identifying, processing, and resolving Member grievances, complaints, or inquiries.

b. **Participation in Quality Improvement Program.** Provider will participate in and comply with Health Plan's QI Program, and will cooperate in conducting peer reviews and audits of care provided by Provider.

c. **Participation in Utilization Review and Management Program.** Provider will participate in and comply with Health Plan's UM Program. Provider will cooperate with Health Plan in audits to identify, confirm, and assess utilization levels of Covered Services.

d. **Participation in Credentialing.** Provider will participate in and satisfy credentialing criteria established by Health Plan before the Effective Date and throughout the term of this Agreement. Provider will promptly notify Health Plan in writing of any change in the information submitted or relied upon by Provider to achieve or maintain credentialed status. In accordance with Health Plan's policies and procedures, Provider must be credentialed by Health Plan or Health Plan's designee before providing Covered Services.

e. **Health Education/Training.** Provider will participate in and comply with Health Plan's Provider education and training efforts, which includes the Cultural Competency Plan and such standards, policies, and procedures as may be necessary for Health Plan to comply with Laws and Government Program Requirements.

2.7 **Provider Manual.** Provider will comply with the Provider Manual, which is incorporated by reference into this Agreement and may be unilaterally amended from time to time by Health Plan. Provider acknowledges the Provider Manual is available to Provider at Health Plan's website. A physical copy of the Provider Manual is available upon request.

2.8 **Supplemental Materials.** Health Plan may periodically issue bulletins or other written materials in order to supplement the Provider Manual or to give additional instruction, guidance, or information ("Supplemental Materials"). Health Plan may issue Supplemental Materials in an electronic format, which includes, but is not limited to, posting on Health Plan's interactive web-portal, and a physical copy is available upon request. Supplemental Materials become binding upon Provider as of the effective date indicated on the Supplemental Materials or, if applicable, the effective date will be determined in accordance with this Agreement.

2.9 **Health Plan's Electronic Processes and Initiatives.** Provider will participate in and comply with Health Plan's electronic processes and initiatives, including, but not limited to, electronic submission of prior authorization, access to electronic medical records, electronic claims filing, electronic data interchange ("EDI"), electronic remittance advice, electronic fund transfers, and registration and use of Health Plan's interactive web-portal.

2.10 **Information Reporting and Changes.** Provider will deliver to Health Plan a complete list of all health care providers, facilities, and business/practice locations it uses to provide Covered Services every thirty (30) days, together with specific information required for credentialing and administration. If Provider does not deliver such information, Health Plan will use the last information received from Provider. Notwithstanding the above, if a Law or Government Program Requirement requires the delivery of information described in this section in another matter or different timeframe, Provider will notify Health Plan in accordance with the Law or Government Program Requirement. Health Plan also reserves the right to request such information at any time.

2.11 **Standing.**

a. **Licensure.** Provider warrants and represents it has the appropriate licenses to provide Covered Services. This includes having and maintaining a current narcotics number issued by proper authorities when appropriate. Provider will deliver evidence of licensure to Health Plan upon request. Provider will maintain its licensure in good standing, free of disciplinary action, and in unrestricted status. Provider will promptly notify Health Plan of changes in its licensure status, including, but not limited to, disciplinary action taken or proposed by any agency responsible for oversight of Provider.

b. **Unrestricted Status.** Provider represents as of the Effective Date of this Agreement that, to its best knowledge, information, and belief, neither it, nor any of its employees, temporary employees, volunteers, consultants and members of its board of directors, officers or contractors (collectively, "Personnel") have been excluded from participation in the Medicare Program, any state or the District of Columbia's Medicaid Program, or any other federal health care program (collectively "Federal Health Care Program"). Provider agrees that it must check the Department of Health and Human Services Office of Inspector General List of Excluded Individuals and Entities ("LEIE" list), the General Services Administration Excluded Parties Lists System ("EPLS") and every state and the District of Columbia's Medicaid exclusion lists to determine whether Provider or any of its Personnel have been excluded from participation in any Federal Health Care Program. These databases must be checked for any new Personnel and thereafter not less than monthly. Provider shall notify Health Plan immediately in writing if Provider determines that Provider or any of its Personnel are suspended or excluded from any Federal Health Care Program. Provider agrees that it is subject to 2 CFR Part 376 and shall require its Personnel to agree that they are subject to 2 CFR Part 376. If a governmental agency imposes a financial adjustment or penalty on Health Plan due to Provider's non-compliance with this provision, Health Plan shall not be obligated to provide subsequent payments owed to Provider under this Agreement and Health Plan shall treat any prior payments, financial adjustments or penalties assessed as an Overpayment.

c. **Malpractice and Other Actions.** Provider will give prompt written notice to Health Plan of: (i) a malpractice claim asserted against it by a Member, a payment made by or on behalf of Provider in settlement or compromise of such a claim, or a payment made by or on behalf of Provider pursuant to a judgment rendered upon such a claim; (ii) a criminal investigation or proceeding against Provider; (iii) a conviction of Provider for crimes involving moral turpitude or felonies; and (iv) a civil claim asserted against Provider that may jeopardize Provider's financial soundness. This section will survive any termination.

d. **Liability Insurance.** Provider will maintain premises and professional liability insurance in coverage amounts appropriate for the size and nature of Provider's facility and health care activities, and in compliance with Laws and Government Program Requirements. If the coverage is claims made or reporting, Provider agrees to purchase similar "tail" coverage upon termination of the Provider's present or subsequent policy. Provider will deliver copies of such insurance policy to Health Plan within five (5) business days of a written request by Health Plan. Provider will deliver advance written notice fifteen (15) business days before any change, reduction, cancellation, or termination of such insurance coverage. This section will survive any termination.

2.12 **Non-Solicitation of Members.** Provider will not solicit or encourage Members to select another health plan.

2.13 **Laws and Government Program Requirements.**

a. **Compliance with Laws and Government Program Requirements.** Provider will comply with Laws that are applicable to this Agreement. Provider acknowledges Health Plan entered into Government Contracts and Provider will comply with the applicable Government Program Requirements that must be satisfied under this Agreement. Upon written request, Health Plan will give Provider a redacted copy of applicable Government Contracts.

b. **Fraud and Abuse Reporting.** Provider will comply with Laws and Government Program Requirements related to fraud, waste, and abuse. Provider will establish and maintain policies and procedures for identifying and investigating fraud, waste, and abuse. In the event Provider discovers an occurrence of fraud, waste, or abuse, Provider will promptly notify Health Plan. Provider will participate in investigations conducted by Health Plan or by state or federal agencies. This section will survive any termination.

c. **Advance Directive.** Provider will comply with Laws and Government Program Requirements related to Advance Directives.

d. **Ownership Disclosure Information.** If applicable, Provider must disclose to Health Plan the name and address of each person, entity, or business with an ownership or control interest in the disclosing entity before the Effective Date and throughout the term of this Agreement. Provider or disclosing entity must also disclose to Health Plan whether any person, entity, or business with an ownership or control interest in the disclosing entity are related to another as spouse, parent, child, or sibling before the Effective Date and throughout the term of this Agreement. Furthermore, there must be disclosure of the name of any other disclosing entity in which a person with an ownership or controlling interest in the Provider or disclosing entity also has an ownership or control interest.

2.14 **Reciprocity Agreements.** Provider will cooperate with Affiliates and agrees to ensure reciprocity of health care services to Affiliate's enrollees. For Affiliate enrollees, Provider will be compensated for Clean Claims that are determined to be payable in accordance with Laws and Government Program Requirements. If there is not a Law or Government Program Requirement governing reimbursement, Provider will be compensated at the rates set forth in this Agreement. Provider will follow the hold harmless provisions of this Agreement for Affiliate's enrollees.

2.15 **Transfer of Members.** Provider will not unilaterally assign or transfer Members to another Participating Provider or non-Participating Provider without the prior written approval of Health Plan.

2.16 **Members Condition Changes.** Upon becoming aware of a significant change in a Member's health or functional status, a Member is being abused or neglected, or a Member death, Provider will notify Health Plan's Member Services department as soon as possible, but not later than seven (7) days.

ARTICLE THREE – HEALTH PLAN'S OBLIGATIONS

3.1 **Member Eligibility Determination.** Health Plan will maintain data on Member eligibility and enrollment. Health Plan will promptly verify Member eligibility at the request of Provider.

3.2 **Prior Authorization Review.** Health Plan will respond with a determination on a prior authorization request in accordance with the time frames governed by Laws and Government Program Requirements after receiving all necessary information from Provider.

3.3 **Medical Necessity Determination.** Health Plan's determination with regard to Medical Necessity, including, but not limited to, determinations of level of care and length of stay, will govern. The primary concern with respect to Medical Necessity determinations is the interest of the Member.

3.4 **Member Services.** Health Plan will provide services to Members, including, but not limited to, assisting Members in selecting a primary care physician, processing Member complaints and grievances, informing Members of Health Plan's policies and procedures, providing Members with membership cards, providing Members with information about Health Plan, and providing Members with access to Health Plan's Provider Directory.

3.5 **Provider Services.** Health Plan will make available a provider services department that, among other Health Plan duties, is available to assist Provider with questions about this Agreement.

3.6 **Corrective Action.** Health Plan, and state and federal agencies routinely monitor the level, manner, and quality of Covered Services provided as well as Provider's compliance with this Agreement. If a deficiency is identified, Health Plan or an agency, in its sole discretion, may choose to issue a corrective action plan. Provider is required to accept and implement such corrective action plan. Provider is not entitled to a corrective action plan prior to any termination.

3.7 **Reassignment of Members.** Health Plan reserves the right to reassign, limit, or deny the assignment or selection of Members to Provider if Health Plan determines that Provider poses a threat to Members' health and safety or during a termination notice period. If Provider requests reassignment of a Member, Health Plan, in its sole discretion, will make the determination regarding reassignment based upon good cause shown by the Provider. When Health Plan reassigns Member, Provider will forward copies of the Member's medical records to the new provider within ten (10) business days of receipt of the Health Plan's or the Member's request to transfer the records.

3.8 **Quality Bonus Payment Program.** Health Plan may offer Provider the opportunity to participate in Health Plan's Quality Bonus Payment Program ("QBPP"). If offered, the QBPP will promote quality of care. Payments under the QBPP are available to Provider based on qualifying criteria and events as described in the Provider Manual and related Supplemental Materials. QBPP payments are not guaranteed and are paid separately from and in addition to the compensation terms of this Agreement.

a. **Eligibility**. To be eligible for the QBPP, Provider must register with Health Plan's interactive web portal. Additionally, Provider must remain in full compliance with this Agreement, which includes, but is not limited, timely and accurate submission of Clean Claims and/or Encounter Data, and remittance of funds due to Health Plan under this Agreement. QBPP documentation submitted by Provider is subject to audit by Health Plan and the program is subject to Laws and Government Program Requirements.

b. **Terms and Conditions.** QBPP payments are subject to terms set forth in the program, which may be modified at any time by Health Plan without notice or amendment. Modifications may include, but are not limited to, exclusions or removal of measures from the program and changes to the calculation and payment methodologies. In the event of a conflict between the Agreement and QBPP, the QBPP will prevail.

ARTICLE FOUR - CLAIMS PAYMENT

4.1 **Claims.** Provider will promptly submit to Health Plan Claims for Covered Services in a standard form that is acceptable to Health Plan. Provider is not eligible for payment on Claims submitted after ninety (90) days from the Date of Service, unless Health Plan is required to follow a different timeframe pursuant to a Law or Government Program Requirement. When Health Plan is the secondary payer, Provider is not eligible for payment for Claims submitted after ninety (90) days from the date the primary payer adjudicated the Claim, unless Health Plan is required to follow a different timeframe pursuant to a Law or Government Program Requirement. Provider will include all medical records pertaining to the Claim if requested by Health Plan and as may be required by Health Plan's policies and procedures.

4.2 **Compensation.** Health Plan will pay Provider for Clean Claims for Covered Services, that are determined to be payable, in accordance with Laws, Government Program Requirements, and this Agreement. Health Plan will make such payment within the timeframes required by Laws or Government Program Requirements. Notwithstanding the previous sentence, Health Plan will make payment within sixty (60) days for Medicare Advantage Claims. Provider agrees to accept such payments, applicable co-payments, co-insurances, deductibles, and coordination of benefits collections as payment in full for Covered Services. Provider's failure to comply with the terms of this Agreement may result in non-payment to Provider.

4.3 **Co-payments and Deductibles.** Provider is responsible for collection of co-payments, co-insurances, and deductibles, if any.

4.4 **Member Hold Harmless.** Provider agrees in no event, including, but not limited to, non-payment, insolvency, or breach of this Agreement by Health Plan, will Provider bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against a Member or person acting on Member's behalf, for Covered Services provided pursuant to this Agreement. This does not prohibit Provider from collecting co-payments, co-insurances, or deductibles as specifically provided in the Member's evidence of coverage or fees for non-Covered Services. This section will survive any termination, regardless of the reason for the termination, including insolvency of Health Plan.

4.5 **Coordination of Benefits.** Health Plan is a secondary payer where another payer is primary payer. Provider will make reasonable inquiry of Members to learn if Member has health insurance or health benefits other than from Health Plan, or is entitled to payment by a third party under any other insurance or plan of any type. Provider will promptly notify Health Plan of said entitlement. In the event a coordination of benefits occurs, Provider will be compensated in an amount equal to the allowable Clean Claim less the amount paid by other health plans, insurance carriers, and payers, not to exceed the amount specified in the Compensation Schedule of this Agreement.

4.6 **Offset.** In the event of an Overpayment, Health Plan may recover the amount owed by: (i) recoupment; or (ii) by way of offset from current or future amounts due Provider. If required, such recoupment or offset will be done in a manner that is compliant with Laws and Government Program Requirements. As a material condition to Health Plan's obligations under this Agreement, Provider agrees the offset and recoupment rights set forth in this

Agreement will be deemed to be and to constitute rights of offset and recoupment authorized under Law or in equity to the maximum extent legally permissible. Such rights will not be subject to any requirement of prior or other approval from a court or other governmental agency that may now or hereafter have jurisdiction over Health Plan or Provider. This section will survive any termination.

4.7 **Claim Review.** Claims will be reviewed and paid in accordance with industry standard billing and payment rules, including, but not limited to, Uniform Billing ("UB") manual and editor, Current Procedural Terminology ("CPT") and Healthcare Common Procedure Coding System ("HCPCS"), federal, and state billing and payment rules, National Correct Coding Initiatives ("NCCI") Edits, and Federal Drug Administration ("FDA") definitions and determinations of designated implantable devices and implantable orthopedic devices. Furthermore, Provider acknowledges Health Plan's right to conduct Medical Necessity reviews and apply clinical practice standards to determine appropriate payment. Payment may exclude certain items not billed in accordance with industry standard billing and payment rules or that do not meet Medical Necessity criteria. This section will survive any termination.

4.8 **Claim Auditing.** Provider acknowledges Health Plan's right to conduct post-payment billing audits. Provider will cooperate with Health Plan's audits of claims and payments by providing access at reasonable times to requested claims information, all supporting medical records, Provider's charging policies, and other related data. Health Plan will use established industry claims adjudication, and clinical practices, state and federal guidelines, and Health Plan's policies and data to determine the appropriateness of the billing, coding, and payment. This section will survive any termination.

4.9 **Financially Responsible Entity Payments.** If Provider provides Covered Services that are the responsibility of a Responsible Entity, Provider will look solely to Responsible Entity for payment of such Covered Services. Pursuant to Health Plan's contract with Responsible Entity, Responsible Entity is to compensate Provider at the rate set forth in Provider's contract with Responsible Entity. If Responsible Entity and Provider do not have a contract or have not agreed to compensation terms, Provider will be reimbursed, as determined by Provider and Responsible Entity, at: (i) one hundred percent (100%) of the governing rates provided by Law specific to the Member's Product in place on the Date of Service; or (ii) at the rates set forth in this Agreement specific to the Member's Product in place on the Date of Service. Except as specifically stated in this section, Provider agrees that the compensation provisions of this Agreement will be binding upon Provider and that Provider will follow the hold harmless provisions of this Agreement.

4.10 **Timely Submission of Encounter Data.** Provider understands Health Plan may have certain contractual reporting obligations that require timely submission of Encounter Data. If a Clean Claim does not contain the necessary Encounter Data, Provider will submit Encounter Data to Health Plan. This section will survive any termination.

ARTICLE FIVE – TERM AND TERMINATION

5.1 **Term.** This Agreement will commence on the Effective Date indicated by Health Plan and will continue in effect until terminated by either Party in accordance with the provisions of this Agreement.

5.2 **Termination without Cause.** This Agreement, an individual Product, or an Individual Provider under this Agreement, may be terminated without cause at any time by either Party by giving at least one hundred twenty (120) days prior written notice to the other Party.

5.3 **Termination with Cause.** In the event of a breach of a material provision of this Agreement, the Party claiming the breach will give the other Party written notice of termination setting forth the facts underlying its claim that the other Party breached this Agreement. The Party receiving the notice of termination will have thirty (30) days from the date of receipt of such notice to remedy or cure the claimed breach to the satisfaction of the other Party. During this thirty (30) day period, the Parties agree to meet as reasonably necessary and to confer in an attempt to resolve the claimed breach. If the Party receiving the notice of termination has not remedied or cured the breach within such thirty (30) day period, the Party who delivered the notice of termination has the right to immediately terminate this Agreement, or an individual Product or an Individual Provider under this Agreement, upon expiration of the thirty (30) day period. Notwithstanding the forgoing, either Party may immediately terminate this Agreement, an individual Product, or an Individual Provider under this Agreement, without providing the other Party the opportunity to cure a material breach should the terminating Party reasonably believe the material breach of this Agreement to be non-curable.

5.4 **Immediate Termination.** Notwithstanding any other provision of this Agreement, this Agreement, an individual Product, or an Individual Provider under this Agreement, may immediately be terminated upon written notice to the other Party in the event any of the following occurs:

a. Provider's license or any other approvals needed to provide Covered Services is limited, suspended, or revoked or disciplinary proceedings are commenced against Provider by applicable regulators and accrediting agencies;

b. Either Party fails to maintain adequate levels of insurance;

c. Provider has not or is unable to comply with Health Plan's credentialing requirements, including, but not limited to, having or maintaining credentialing status;

d. Either Party becomes insolvent or files a petition to declare bankruptcy or for reorganization under the bankruptcy laws of the United States, or a trustee in bankruptcy or receiver for Provider or Health Plan is appointed by appropriate authority;

e. If Provider is capitated and Health Plan determines Provider is financially incapable of bearing capitation or other applicable risk-sharing compensation methodology;

f. Health Plan reasonably determines that Provider's facility or equipment is insufficient to provide Covered Services;

g. Either Party is excluded from participation in state or federal health care programs;

h. Provider is terminated as a provider by any state or federal health care program;

i. Either Party engages in fraud or deception, or permits fraud or deception by another in connection with each Party's obligations under this Agreement;

j. Health Plan reasonably determines that Covered Services are not being properly provided, or arranged for by Provider, and such failure poses a threat to Members' health and safety;

k. Provider violates any state or federal law, statute, rule, regulation or executive order; or

l. Provider fails to satisfy the terms of a corrective action plan.

5.5 **Notice to Members.** In the event of any termination, Health Plan will give reasonable advance notice to Members who are currently receiving care in accordance with Laws and Government Program Requirements.

5.6 **Transfer Upon Termination.** In the event of any termination, Health Plan may transfer Members to another provider.

ARTICLE SIX – GENERAL PROVISIONS

6.1 **Indemnification.** Each Party will indemnify and hold harmless the other Party and its officers, directors, shareholders, employees, agents, and representatives from any and all liabilities, losses, damages, claims, and expenses of any kind, including costs and attorneys' fees, which result from the duties and obligations of the indemnifying Party or its officers, directors, shareholders, employees, agents, and representatives under this Agreement.

6.2 **Relationship of the Parties.** Nothing contained in this Agreement is intended to create, nor will it be construed to create, any relationship between the Parties other than that of independent parties contracting with each other solely for the purpose of effectuating this Agreement. This Agreement is not intended to create a relationship of agency, representation, joint venture, or employment between the Parties. Nothing herein contained will prevent the Parties from entering into similar arrangements with other parties. Each Party will maintain separate and independent management and will be responsible for its own operations. Nothing contained in this Agreement is intended to create, nor will it be construed to create, any right in any third party to enforce this Agreement.

6.3 **Governing Law.** The laws of the State of New York will govern this Agreement.

6.4 **Entire Agreement.** This Agreement, including attachments, appendices, addenda, amendments, Supplemental Materials, and incorporated documents or materials, contains the entire agreement between the Parties relating to the rights granted and obligations imposed by this Agreement. Any prior agreements, promises, negotiations, or

representations, either oral or written, between the Parties and relating to the subject matter of this Agreement, are of no force or effect.

6.5 **Severability.** If a term, provision, covenant, or condition of this Agreement is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remaining provisions will remain in full force and effect and will in no way be affected, impaired, or invalidated as a result of such decision.

6.6 **Headings and Construction.** The headings in this Agreement are for reference purposes only and are not considered a part of this Agreement in construing or interpreting its provisions. It is the Parties' desire that if a provision of this Agreement is determined to be ambiguous, then the rule of construction that such provision is construed against its drafter will not apply to the interpretation of the ambiguous provision. The following rules of construction apply to this Agreement: (i) the word "day" means calendar day unless otherwise specified; (ii) the term "business day" means Monday through Friday, except federal holidays; (iii) all words used in this Agreement will be construed to be of such gender or number as circumstances require; (iv) references to specific statutes, regulations, rules or forms, such as CMS-1500, include subsequent amendments or successors to them; and (v) references to any government department or agency include any successor departments or agencies.

6.7 **Non-exclusivity.** This Agreement will not be construed to be an exclusive Agreement between the Parties. Nor will it be deemed to be an Agreement requiring Health Plan to refer Members to Provider.

6.8 **Amendments.**

a. **Regulatory Amendments.** Health Plan may immediately amend this Agreement to maintain consistency or compliance with applicable policy, directive, Law, or Government Program Requirement at any time and without Provider's consent. Such regulatory amendment will be binding upon Provider.

b. **Non-Regulatory Amendments.** Notwithstanding the Regulatory Amendments section, Health Plan may otherwise amend this Agreement upon thirty (30) days prior written notice to Provider. If Provider does not deliver a written disapproval to such amendment within the thirty (30) day period, the amendment will be deemed accepted by and binding upon Provider. If Health Plan receives a written disapproval within the thirty (30) day period, the Parties agree to meet and confer in good faith to determine if a revised amendment can be accepted by and binding upon the Parties.

6.9 **Delegation or Subcontract.** Upon the Effective Date, Provider will submit to Health Plan a list identifying each of Provider's Subcontractors and a description of the services the Subcontractor provides. After the Effective Date, Provider will not subcontract with a Subcontractor without the prior written consent of Health Plan. Such arrangement with a Subcontractor will be in writing and will bind Subcontractor to the terms required by Health Plan.

6.10 **Assignment.** Provider may not assign or transfer, in whole or in part, any rights, duties, or obligations under this Agreement without the prior written consent of Health Plan. Subject to the foregoing, this Agreement is binding upon, and inures to the benefit of the Parties and respective successors in interest and assignees. Neither the acquisition of Health Plan nor a change of its legal name shall be deemed an assignment.

6.11 **Dispute Resolution.**

a. **Meet and Confer.** Any claim or controversy arising out of or in connection with this Agreement will first be resolved, to the extent possible, via "Meet and Confer". The Meet and Confer will begin when one Party delivers written notice to the other that it intends to arbitrate a dispute and the basis for its belief that it will prevail in arbitration. After providing notice of the intent to arbitrate, the Meet and Confer will be held as an informal face-to-face meeting held in good faith between appropriate representatives of the Parties and at least one (1) person authorized to settle outstanding claims and pending arbitration matters. The Parties will commence the face-to-face portion of the Meet and Confer within forty-five (45) days of receiving notice of an intent to arbitrate or service of an arbitration demand. Such face-to-face Meet and Confer discussion will occur at a time and location agreed to by the Parties (within the forty-five (45) days) and if both Parties agree that more face-to-face discussions would be beneficial, the Parties can agree to have more than one (1) in person settlement discussion or a combination of in person, phone meetings and exchange of correspondence.

b. **Arbitration.** The Parties agree that any dispute not resolved via Meet and Confer will be settled in binding arbitration administered by Judicial Arbitration and Mediation Services ("JAMS"), or if mutually agreed upon, pursuant to another agreed upon Alternative Dispute Resolution ("ADR") provider in accordance with that ADR provider's Commercial Arbitration Rules, in Onondaga County, NY. However, matters that primarily involve Provider's professional competence or conduct i.e., malpractice, professional negligence, or wrongful death will not be eligible for arbitration.

Any arbitration in which the total amount disputed by one Party is equal to or exceeds one million dollars ($1,000,000.00) will be resolved by a panel of three (3) arbitrators. In the event a panel of three (3) arbitrators will be used, the claimant will select one (1) arbitrator; the respondent will select one (1) arbitrator; and the two (2) arbitrators selected by the claimant and respondent will select the third arbitrator whose determination will be final and binding on the Parties. If possible, each arbitrator will be an attorney with at least fifteen (15) years of experience, including at least five (5) years of experience in managed health care.

Any arbitration in which the total amount disputed by one Party is equal to or exceeds five hundred thousand dollars ($500,000.00), but less than one million dollars ($1,000,000.00), the claimant and respondent will each select a single arbitrator and the two (2) arbitrators selected by the claimant and respondent will select a single arbitrator who will be responsible for the arbitration proceedings ("Selected Arbitrator"). Each Party can strike no more than one (1) Selected Arbitrator. The Selected Arbitrator will be an attorney with at least fifteen (15) years of experience, including at least five (5) years of experience in managed health care.

Any arbitration in which the total amount disputed by one Party is less than five hundred thousand dollars ($500,000.00) will be resolved by a single arbitrator. In the event a single arbitrator is used, the arbitrator will be an attorney with at least fifteen (15) years of experience, including at least five (5) years of experience in managed health care.

The arbitrator will apply New York substantive law and Federal substantive law where State law is preempted. Civil discovery for use in such arbitration may be conducted in accordance with federal rules of civil procedure and federal evidence code, except where the Parties agree otherwise. The arbitrator selected will have the power to enforce the rights, remedies, duties, liabilities, and obligations of discovery by the imposition of the same terms, conditions, and penalties as can be imposed in like circumstances in a civil action by a court in the same jurisdiction. The provisions of federal rules of civil procedure concerning the right to discovery and the use of depositions in arbitration are incorporated herein by reference and made applicable to this Agreement. However, in any arbitration in which the total amount disputed by one Party is less than one million dollars ($1,000,000.00) the Parties agree that each Party will have the right to take no more than three (3) depositions of individuals or entities, excluding deposition of expert witnesses, and the Parties agree to exchange copies of all exhibits and demonstrative evidence to be used at the arbitration prior to the arbitration as deemed appropriate by the arbitrator. The Parties agree that in any arbitration in which the total amount disputed by one Party is less than five hundred thousand dollars ($500,000.00) each Party will have the right to take no more than one (1) deposition of individuals or entities and one (1) expert witness, and the Parties agree to exchange copies of all exhibits and demonstrative evidence to be used at the arbitration prior to the arbitration as deemed appropriate by the arbitrator. Regardless of the amount in dispute, rebuttal and impeachment evidence need not be exchanged until presented at the arbitration hearing.

The arbitrator will have no authority to give a remedy or award damages that would not be available to such prevailing Party in a court of law, nor will the arbitrator have the authority to award punitive or liquidated damages. The arbitrator will deliver a written reasoned decision within thirty (30) days of the close of arbitration, unless an alternate agreement is made during the arbitration. The Parties agree to accept any decision by the arbitrator, which is grounded in applicable law, as a final determination of the matter in dispute, and judgment on the award rendered by the arbitrator may be entered in any court having jurisdiction. The award may be reviewed, vacated, or modified pursuant to the Federal Arbitration Act ("FAA"), 9 USC sections 9-11. Grounds for vacating an award, include where the award was procured by corruption, fraud, or undue means, and where the arbitrators were guilty of misconduct, exceeded their powers, evident material miscalculation, evident material mistake, imperfect(ions) in (a) matter of form not affecting the merits, and where a decision is not grounded in applicable law. When a decision is not grounded in applicable law, any Party will have the right to appeal the decision in addition to those rights to vacate or appeal already existing

pursuant to the FAA or applicable state arbitration laws. Any such appeal may be made to a court having jurisdiction over the Parties or the dispute. Notice of intent to Appeal based on failure to render a decision grounded in law must be given to the other Party within fifteen (15) days after the decision is communicated to the Parties; and the appeal must be formally initiated by filing in court within thirty (30) days after the decision is communicated to the Parties. If a court decides it will not hear an appeal because it deems appeals from arbitration not subject to appeal, there is no right for any additional appeal in any other venue.

Each Party shall bear its own costs and expenses, including its own attorneys' fees, and shall bear an equal share of the arbitrator and administrative fees of arbitration. The parties agree that one or the other may request a court reporter transcribe the entire proceeding, in which case the parties will split the cost of the court reporter, but each may elect to purchase or forego purchasing a transcript.

Arbitration must be initiated within one (1) year of the earlier of the date the claim or controversy arose, was discovered, or should have been discovered with reasonable diligence; otherwise it will be deemed waived. The use of binding arbitration will not preclude a request for equitable and injunctive relief made to a court of appropriate jurisdiction.

The Parties to this Agreement acknowledge that the New York 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.

6.12 **Notice.**

a. **Delivery.** All notices required or permitted by this Agreement, except for Supplemental Materials, will be in writing and delivered: (i) in person; (ii) by U.S. Postal Service ("USPS") registered, certified, or express mail with postage prepaid; (iii) by overnight courier that guarantees next day delivery; (iv) by facsimile transmission; or (v) by email. Notice is deemed given: (i) on the date of personal delivery; (ii) on the second day after the postmark date for USPS registered, certified, or express mail with postage prepaid; (iii) on the date of delivery shown by overnight courier; or (iv) on the date of transmission for facsimile or email.

b. **Addresses.** The mailing address, email address, and facsimile number set forth under the Signature Page will be the particular Party's information for delivery of notice. Each Party may change its information through written notice in compliance with this section without amending this Agreement. Notice will be sent to the attention of the Authorized Representative.

6.13 **Waiver.** A failure or delay of a Party to exercise or enforce any provision of this Agreement will not be deemed a waiver of any right of that Party. Any waiver must be specific, in writing, and executed by the Parties.

6.14 **Execution in Counterparts and Duplicates.** This Agreement may be executed in counterparts, each of which will be deemed an original, but all of which together will constitute one and the same instrument. The Parties agree facsimile signatures, pdf signatures, photocopied signatures, electronic signatures, or signatures scanned and sent via email will have the same effect as original signatures.

6.15 **Conflict with Health Plan Product.** Nothing in this Agreement modifies any benefits, terms, or conditions contained in the Member's Product. In the event of a conflict between this Agreement and any benefits, terms, or conditions of a Product, the benefits, terms, and conditions contained in the Member's Product will govern.

6.16 **Force Majeure.** Neither Party will be liable or deemed to be in default for any delay or failure to perform any act under this Agreement resulting directly or indirectly, from acts of God, civil or military authority, acts of a public enemy, war, accident, fire, explosion, earthquake, flood, strikes by either Party's employees, or any other similar cause beyond the reasonable control of such Party.

6.17 **Confidentiality.** Any information disclosed by either Party in fulfillment of its obligations under this Agreement, including, but not limited to, health care information, compensation rates, and the terms of the Agreement, will be kept confidential. Information provided to Provider, including, but not limited to, Member lists, QI Program, credentialing criteria, compensation rates, and any other administrative protocols or procedures of Health Plan, is the proprietary property of Health Plan and will be kept confidential. Provider will not disclose or release such material to a third party without the written consent of Health Plan. This section will survive any termination.

6.18 **Incorporation of Standard Clauses.** The "New York State Department of Health Standard Clauses for Managed Care Provider/IPA/ACO Contracts", attached to the Agreement as Attachment D, are expressly incorporated into this Agreement and are binding upon the Article 44 plans and providers that contract with such plans, and who are a party to this Agreement. 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 applicable law requires otherwise and/or to the extent a provision of the Agreement exceeds the minimum requirements of the Standard Clauses.

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ATTACHMENT A

Products

1.1 **Medicaid** – including, but not limited to, Medicaid Managed Care ("MMC"), HIV Special Needs Plan, Health and Recovery Plans ("HARP") and any other Medicaid programs Health Plan offers in the future.

1.2 **CHP** – including, but not limited to, Child Health Plus.

1.3 **Essential Plan –** including, but not limited to, Essential Plans 1, 2, 3, and 4.

1.4 **Medicare Advantage** – including, but not limited to, Molina Medicare Options, Molina Medicare Options Plus and any other Medicare Advantage programs Health Plan offers in the future.

1.5 **Medicare-Medicaid Program** – As of the Effective Date of this Agreement, this Product is not an operational Product for Health Plan either because Health Plan does not participate in such Product or the Product is not currently offered in the State. If at a future date this Product becomes operational for Health Plan, Provider will be automatically contracted with Health Plan for this Product at that time and the terms of this Agreement shall be applicable to this Product.

1.6 **Health Insurance Marketplace** – As of the Effective Date of this Agreement, this Product is not an operational Product for Health Plan either because Health Plan does not participate in such Product or the Product is not currently offered in the State. If at a future date this Product becomes operational for Health Plan, Provider will be automatically contracted with Health Plan for this Product at that time and the terms of this Agreement shall be applicable to this Product.

ATTACHMENT B

Compensation Schedule

1.1 **Compensation for Medicaid and CHP.** Health Plan agrees to compensate Provider on a fee-for-service basis for Covered Services provided under the Medicaid and CHP Products, that are determined by Health Plan to be payable and submitted on a Clean Claim, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any, at the least of the following amounts in effect on the Date of Service: (i) Provider's billed charges; (ii) an amount equivalent to the Medicaid Fee-For-Service Program allowable payment rate set forth by the State of New York; or (iii) an amount equivalent to the Medicare Fee-For-Service Program allowable payment rate set forth by CMS. The Medicare Fee-For-Service Program allowable payment rate deducts any cost sharing amounts, including, but not limited to, co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties that would have been deducted if the Member were enrolled in the Medicare Fee-For-Service Program. Notwithstanding the above, unless prohibited by Law, Provider agrees that in the event there is a retroactive change to the Medicaid or Medicare Fee-For-Service Program allowable payment rate, Health Plan shall have sole discretion to determine if claims will be reprocessed when payment has already been issued to Provider.

1.2 **Compensation for Essential Plan**. Health Plan agrees to compensate Provider on a fee-for-service basis for Covered Services provided under the Essential Plan Product, that are determined by Health Plan to be payable and submitted on a Clean Claim, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any, at the least of the following amounts in effect on the Date of Service: (i) Provider's billed charges; (ii) an amount equivalent to the Medicaid Fee-For-Service Program allowable payment rate set forth by the State of New York; or (iii) an amount equivalent to the Medicare Fee-For-Service Program allowable payment rate set forth by CMS. The Medicare Fee-For-Service Program allowable payment rate deducts any cost sharing amounts, including, but not limited to, co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties that would have been deducted if the Member were enrolled in the Medicare Fee-For-Service Program. Notwithstanding the above, unless prohibited by Law, Provider agrees that in the event there is a retroactive change to the Medicaid or Medicare Fee-For-Service Program allowable payment rate, Health Plan shall have sole discretion to determine if claims will be reprocessed when payment has already been issued to Provider.

1.3 **Compensation for Medicare Advantage.** Health Plan agrees to compensate Provider on a fee-for-service basis for Covered Services provided under the Medicare Advantage Product, that are determined by Health Plan to be payable and submitted on a Clean Claim, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any, at the lesser of the following amounts in effect on the Date of Service: (i) Provider's billed charges; or (ii) at an amount equivalent to the Medicare Fee-For-Service Program allowable payment rates. The Medicare Fee -For- Service Program allowable payment rate deducts any cost sharing amounts, including, but not limited to, co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties that would have been deducted if the Member were enrolled in the Medicare Fee-For-Service Program. Notwithstanding the above, unless prohibited by Law, Provider agrees that in the event there is a retroactive change to the Medicare Fee-For-Service Program allowable payment rate, Health Plan shall have sole discretion to determine if claims will be reprocessed when payment has already been issued to Provider.

1.4 **Compensation for Medicare-Medicaid Program.** Health Plan agrees to compensate Provider on a fee-for-service basis for Covered Services provided under the Medicare-Medicaid Program Product, that are determined by Health Plan to be payable and submitted on a Clean Claim, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any, at the lesser of the following amounts in effect on the Date of Service: (i) Provider's billed charges; or (ii) pursuant to the methodology described below.

Provider will receive an amount equivalent to the Medicare Fee-For-Service Program allowable payment rates, and any portion, if any, that the Medicaid agency or Medicaid managed care plan would have been responsible for paying if the Member was enrolled in the Medicare Fee-For-Service Program. The Medicare Fee-For-Service Program allowable payment rate deducts any cost sharing amounts, including, but not limited to, co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties that would have been deducted if the Member were enrolled in the Medicare Fee-For-Service Program. Notwithstanding the above, unless

prohibited by Law, Provider agrees that in the event there is a retroactive change to the Medicare Fee-For-Service Program allowable payment rate, Health Plan shall have sole discretion to determine if claims will be reprocessed when payment has already been issued to Provider.

In the event the Provider bills for Covered Services covered by Medicaid or that are primary to Medicaid, but not Medicare, Health Plan agrees to compensate Provider on a fee-for-service basis for such Covered Services provided that are determined by Health Plan to be payable and submitted on a Clean Claim, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any at the lesser of the following amounts in effect on the Date of Service: (i) Provider's billed charges; or (ii) an amount equivalent to the Medicaid Fee-For-Service Program allowable payment rates set forth by the State of New York. Notwithstanding the above, unless prohibited by Law, Provider agrees that in the event there is a retroactive change to the Medicaid Fee-For-Service Program allowable payment rate, Health Plan shall have sole discretion to determine if claims will be reprocessed when payment has already been issued to Provider.

1.5 **Compensation for Health Insurance Marketplace.** Health Plan agrees to compensate Provider on a fee-for-service basis for Covered Services provided under the Health Insurance Marketplace Product, that are determined by Health Plan to be payable and submitted on a Clean Claim, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any, at the lesser of the following amounts in effect on the Date of Service: (i) Provider’s billed charges; or (ii) at an amount equivalent to the Medicare Fee-For-Service Program allowable payment rates. The Medicare Fee-For-Service Program allowable payment rate deducts any cost sharing amounts, including, but not limited to, co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties that would have been deducted if the Member were enrolled in the Medicare Fee-For-Service Program. Notwithstanding the above, unless prohibited by Law, Provider agrees that in the event there is a retroactive change to the Medicare Fee-For-Service Program allowable payment rate, Health Plan shall have sole discretion to determine if claims will be reprocessed when payment has already been issued to Provider.

In the event that there is no payment rate under the Medicare Fee-For-Service Program allowable payment rate, Covered Services determined by Health Plan to be payable and submitted on a Clean Claim will be paid on a fee-for-service basis, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any, at the lesser of the following amounts in effect on the Date of Service: (i) Provider’s billed charges; or (ii) an amount equivalent to the Medicaid Fee-For-Service Program allowable payment rate set forth by the State of New York. Notwithstanding the above, unless prohibited by Law, Provider agrees that in the event there is a retroactive change to the Medicaid Fee-For-Service Program allowable payment rate, Health Plan shall have sole discretion to determine if claims will be reprocessed when payment has already been issued to Provider.

ATTACHMENT C

State of New York Required Provisions

State Laws

This attachment sets forth applicable State Laws or other provisions necessary to reflect compliance with State Laws. This attachment will be automatically modified to conform to subsequent changes to Law. All provisions of the Agreement not specifically modified by this attachment remain unchanged and will control. In the event of a conflict between this attachment and any other provision in the Agreement, the provisions in this attachment will control. Capitalized terms used in this attachment will have the same meaning ascribed to them in the Agreement unless otherwise set forth in this attachment. Any purported modification or any provision in this attachment that is inconsistent with Law will not be effective and will be interpreted in a manner that is consistent with the applicable Law. For the avoidance of doubt, this attachment does not apply to the Medicare Advantage Product or the Medicare-Medicaid Product to the extent such Products are preempted by Federal Law.

1.1 **Emergency Services.** Provider shall not be required to seek prior authorization for Emergency Services before the Member has been stabilized. Once a Member who receives Emergency Services is stabilized, Provider shall seek prior authorization for post-stabilization care services for the Member in accordance with the Provider Manual.

1.2 **Deficit Reduction Act.** As required by section 6032 of the Deficit Reduction Act of 2005, if Provider makes or receives annual Medicaid payments of Five Million Dollars or more it will (a) establish and maintain written policies for all of its employees and its contractors and agents that provide information about the False Claims Act, 31 USC §§ 3729-3733, other administrative remedies, state laws pertaining to civil and criminal penalties for false claims or statements, and whistleblower protection under such Laws, (b) include as part of its written policies detailed provisions outlining the entity's policies and procedures for detecting and preventing fraud, waste and abuse, and (c) include in any employee handbook a discussion of the relevant laws and administrative remedies, a discussion of whistleblower protections afforded to employees, and the entity's policies and procedures for detecting fraud.

1.3 **HCRA.** If applicable, Provider, if a hospital licensed under Article 28 of the Public Health Law, shall cooperate with Health Plan in the event of any audit by the New York State Department of Health or CMS, or any designee of such agency, and within five business days of a request, Provider shall provide any and all required documentation to Health Plan attesting that such physician practices and/or faculty practices are discretely billing for private practicing physician services. Thus, that such payments are not subject to New York State Health Care Reform surcharges. Provider shall indemnify and hold Health Plan harmless for any costs incurred as a result of Provider's failure to provide any such required documentation.

1.4 **Cooling Off Period.** Provider, if a hospital licensed under Article 28 of the Public Health Law, shall comply with the provisions of New York State Public Health Law 4406-c(5-c) following the termination or non-renewal of this Agreement.

1.5 **Continuation of Treatment Post-Termination.** In accordance with New York State Public Health Law 4403.6(e), upon termination or non-renewal of this Agreement, Provider shall allow Members to continue an ongoing course of treatment with Providers during a transitional period of (a) up to ninety (90) days from the date of notice to the Member of the termination or non-renewal; or (b) if the Member has entered the second trimester of pregnancy at the time of termination or non-renewal, for a transitional period that includes the provision of post-partum care directly related to the delivery. Provider shall continue to accept the rates set forth in this Agreement for such transitional care services and to adhere to Health Plan's quality assurance and all policy and procedure requirements.

1.6 **Deemed Credentialed.** If Provider is a group practice, then any newly-licensed health care professional, or health care professional who has recently relocated to New York State from another State, is neither approved nor declined within ninety (90) days of application for credentialing, the health care professional shall be deemed provisionally credentialed in accordance with New York State Public Health Law §4406-D.

1.7 **Prompt Payment.** The Parties shall comply with New York State Insurance Law § 3224-a. Except for fraud or where the obligation of Health Plan is not reasonably clear, electronically submitted claims must be paid within thirty (30) days of receipt of the claim or bill for services rendered, and claims submitted on paper or through fax must be paid within forty-five (45) days of receipt of the claim or bill for services rendered. Otherwise, Health Plan shall deny the claim or ask for additional information within thirty (30) days of receipt of the claim or bill for services rendered.

1.8 **Late Claim Submission.** The Parties agree to comply with New York State Insurance Law §§ 3224-a (g) and (h), which requires that Provider shall have at least ninety (90) days after the date of service to submit claims to Health Plan. Notwithstanding, Health Plan shall pay a Provider's late claim if Provider can show that the untimeliness was the result of an "unusual occurrence" and that Provider has a pattern of timely claim submissions. However, Health Plan may reduce payment on a late claim by up to twenty five percent (25%). If a claim is submitted one year or more after the date of service, Health Plan may deny the claim in its entirety.

1.9 **Overpayment.** The Parties shall comply with New York Insurance Law § 3224-b, which requires that Health Plan provide Provider thirty (30) days advance written notice before Health Plan engages in additional overpayment recovery efforts seeking recovery of overpayments, other than duplicate payments. Such notice shall state the patient name, service date, payment amount, proposed adjustment and provide a reasonably specific explanation of the proposed adjustment. A Provider may challenge any overpayment recovery pursuant to Health Plan's policies and procedures, provided such challenge sets forth the specific grounds on which the Provider is challenging the overpayment recovery.

1.10 **Member Communications.** In the event that a Provider is an IPA, an institutional network provider or medical group provider that serves five percent (5%) or more of the enrolled population in a county, and ceases participation in Health Plan's network, any written notification to Members by the Provider shall be submitted to the New York state Department of Health for review and approval.

1.11 **Adverse Reimbursement Change.** In the event this Agreement covers services of a Health Care Professional (as defined below), any amendment that modifies the compensation attachment relating to this Program Attachment in a manner that can be reasonably expected to have a material adverse impact on the aggregate level of payment shall be issued with ninety (90) days written notice. For the purpose of this section only, a "**Health Care Professional**" shall mean a health care professional licensed, registered or certified pursuant to Title Eight of the New York State Education Law. If Provider objects to such amendment, Provider may give notice of such objection and intent to terminate the Agreement effective upon the implementation date of the adverse reimbursement change within thirty (30) days of receipt of Health Plan's notice of such amendment. Health Plan may accept such termination or modify or withdraw the amendment. This shall not apply where such change is otherwise required by laws or Government Program, or is required as a result of changes in fee schedules, reimbursement methodology or payment policies established by a governmental authority or by the American Medical Association's Current Procedural Terminology (CPT) codes, reporting guidelines and conventions; or such change is expressly provided for under the terms of the Agreement by the inclusion of or reference to a specific fee or fee schedule, reimbursement methodology or payment policy indexing mechanism. Nothing in this section, however, shall create a private right of action on behalf of Provider or Provider against Health Plan for any violation of this section.

1.12 **FQHCs / RHCs.** If Provider enters into a subcontract with an FQHC or RHC, Provider shall reimburse the FQHC/RHC at the same reimbursement level as Health Plan would reimburse other providers for the same services.

ATTACHMENT D

New York State Department of Health Standard Clauses For Managed Care Provider/IPA/ACO Contracts

Attachment (Revised 4/1/17)

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 Attachment**

"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," Attachment E 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 Attachment, 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.

ATTACHMENT E Certification

Regarding Lobbying

The undersigned certifies, to the best of his or her knowledge, that:

1.1 No Federal appropriated funds have been paid or will be paid to any person by or on behalf of the 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 a Member of Congress in connection with the award of any Federal loan, the entering into any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

1.2 If any funds other than Federal 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 in connection with the award of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into any cooperative agreement, or the extension, continuation, renewal, amendment or modification of this Federal contract, grant, loan, or cooperative agreement, and the Agreement exceeds $100,000, the Provider shall complete and submit Standard Form-LLL "Disclosure Form to Reporting Lobby," 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 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: 12/29/2023

TITLE: Owner

ORGANIZATION: Mind Orientation Applied Behavior Analysis

NAME: (Please Print): Zlaty Kahan

SIGNATURE: DocuSigned by: 6A7ABD7018124A5...

ATTACHMENT F

Medicaid and CHP

Laws and Government Program Requirements

This attachment sets forth applicable Laws and Government Program Requirements, or other provisions necessary to reflect compliance for the Medicaid and, as applicable, CHP Products. This attachment will be automatically modified to conform to subsequent changes to Laws or Government Program Requirements. All provisions of the Agreement not specifically modified by this attachment remain unchanged and will control. In the event of a conflict between this attachment and any other provision in the Agreement, except Attachment D, the provisions in this attachment will control for the Medicaid and, as applicable, CHP Products. In the event there is a conflict between this attachment and Attachment D, the provisions of Attachment D will control. Capitalized terms used in this attachment will have the same meaning ascribed to them in the Agreement unless otherwise set forth in this attachment. Any purported modification or any provision in this attachment that is inconsistent with a Law or Government Program Requirement will not be effective and will be interpreted in a manner that is consistent with the applicable Law and Government Program Requirement. This attachment only applies to Medicaid and, as applicable, CHP Products.

1.1 If Provider participates in the MMC Product, upon Member consent, Provider will provide medical documentation and health, mental health, and chemical dependence assessments as noted below.

a. Within ten (10) days of a request of Member or a former Member, currently receiving public assistance or who is applying for public assistance, Member's or former Member's Primary Care Provider ("PCP") or specialist provider, as appropriate, shall provide medical documentation concerning Member or former Member's health or mental health status to the Local Department of Social Services ("LDSS") or to the LDSS' designee. Medical documentation, includes, but is not limited to, drug prescriptions and reports from Member's PCP or specialist provider.

b. Within ten (10) days of a request of a Member, who has already undergone, or is scheduled to undergo, an initial LDSS required mental and/or physical examination, the Member's PCP shall provide a health, or mental health and/or chemical dependence assessment, examination or other services as appropriate to identify or quantify a Member's level of incapacitation. Such assessment must contain a specific diagnosis resulting from any medically appropriate tests and specify any work limitations. The LDSS, may, upon written notice to the Health Plan, specify the format and instructions for such an assessment.

1.2 Provider will comply with lead poisoning screening and follow-up as specified in 10 NYCRR Sub-part 67-1. Providers will coordinate with the Local Public Health Agency ("LPHA") to assure appropriate follow-up in terms of environmental investigation, risk management, and reporting requirements.

1.3 Providers will report positive HIV test results and diagnoses and known contacts of such persons to the New York State Commissioner of Health. In New York City, these shall be reported to the New York City Commissioner of Health and Mental Hygiene. Access to partner notification services must be consistent with 10 NYCRR Part 63.

1.4 Provider will maintain appropriate records relating to Health Plan performance under this Agreement, including: (i) records related to services provided to Members, including a separate medical record for each Member; (ii) all financial records and statistical data that LDSS, New York State Department of Health ("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, any reserves related thereto and expenses incurred under this Agreement; (iii) all documents concerning enrollment fraud or the fraudulent use of any Client Identification Number ("CIN"); (iv) all documents concerning duplicate CINs; (v) appropriate financial records to document fiscal activities and expenditures, including records relating to the sources and application of funds and to the capacity of the Health Plan or its subcontractors, including Provider, if applicable, to bear the risk of potential financial losses; and (vi) Provider shall maintain appropriate records identifying every subcontract to this Agreement, including any and all agreements arising out of said subcontract.

1.5 Provider will offer hours of operation that are no less than the hours of operation offered to commercial members or, if Provider serves only MMC and/or FHPlus Member, comparable to hours offered for Medicaid fee-for-service patients.

1.6 The following provisions apply to a provider contracted and, as applicable, credentialed by Health Plan or Health Plan's designee as PCPs.

a. PCPs must practice a minimum of sixteen (16) hours a week at each primary care site.

b. PCPs will participate annually in at least ten (10) hours of Continuing Medical Education that is consistent with guidelines for HIV specialty care as determined by the AIDS Institute.

1.7 The following provision applies to a provider contracted and, as applicable, credentialed by Health Plan or Health Plan's designee as a Federally Qualified Health Center ("FQHC"), Health Plan agrees to compensate Provider for Covered Services provided to Members at a payment rate that is not less than the level and amount that Health Plan would pay another Participating Provider that is not an FQHC for a similar set of Covered Services.

1.8 The following provision applies to a provider contracted and, as applicable, credentialed by Health Plan or Health Plan's designee as a retail pharmacy provider, Provider will collect a paper or electronic signature to confirm pick-up or receipt of each prescription and Over the Counter ("OTC") drug. In lieu of maintaining a signature log, network pharmacies providing drugs via mail order must maintain the applicable shipping information, including the Member's name, address and prescription number, shipped date and carrier. This information may be maintained electronically or on paper. Prescriptions for controlled substances require a signature upon delivery and must be shipped by a method that can be tracked. Signatures must be maintained consistent with requirements in the contract between the Health Plan and SDOH.

1.9 The following provision applies to a provider contracted and, as applicable, credentialed by Health Plan or Health Plan's designee as a Durable Medical Equipment ("DME") provider, DME Providers will collect a signature to confirm pick-up of medical supplies. All electronic signatures must be retrievable. Signatures must be maintained consistent with requirements in the contract between the Health Plan and SDOH.

1.10 In the event Health Plan delegates activities to Provider, Health Plan and Provider will execute a delegated services agreement/amendment that delineates the activities and report responsibilities delegated to Provider; and provide for revoking the delegation, in whole or in part, and imposing other sanctions if Provider's performance does not satisfy standards set forth in the contract between the Health Plan and SDOH, and an obligation for Provider to take corrective action.

1.11 The statutes, rules, regulations, and applicable Medicaid Updates of the Medicaid program and of SDOH related to the furnishing of medical care, services or supplies provided directly by, or under the supervision of, or ordered, referred or prescribed by Provider enrolled with Health Plan apply to Provider and any subcontractors, regardless of whether the Provider or subcontractor is an enrolled Medicaid provider, including 18 NYCRR 515.2, except to the extent that any reference in the regulations establishing rates, fees, and claiming instructions will refer to the rates, fees and claiming instructions set by Health Plan.

1.12 Notwithstanding any other provision of this Agreement: (i) this Agreement will not limit or terminate Health Plan's obligation under the contract between the Health Plan and SDOH; and (ii) this Agreement will not limit any right to commence an action or to obtain recovery from Provider by the State, including, but not limited to, the New York State Office of the Attorney General ("OAG"), SDOH, Office of Medicaid Inspector General ("OMIG") and the New York State Office of the State Comptroller ("OSC"), even under circumstances where Health Plan obtained an overpayment recovery from Provider. Nothing in this Agreement shall be construed to limit the amount of any recovery sought or obtained by the OAG, SDOH, OMIG, and OSC from any Provider.

1.13 Nothing in this Agreement creates a contractual relationship between Provider and SDOH. Nothing in this paragraph shall be construed to limit the authority of the New York State Office of the Attorney General to commence any action pursuant to 31 USC§ 3729 et seq., State Finance Law § 187 et seq., Social Services Law § 145-b or other New York or Federal statutes, regulations or rules.

1.14 Provider will comply with requirements of 42 CFR 438 that are to the service or activity delegated under this Agreement.

1.15 Provider will comply with Health Plan's dispute resolution procedures as noted in the Provider Manual.

1.16 Provider will comply with the informed consent procedures for Hysterectomy and Sterilization specified in 42 CFR Part 441, sub-part F, and 18 NYCRR § 505.13.

1.17 The 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 a provider is terminated from, not accepted to, or fails to submit a designated enrollment application to, the New York State Medicaid Program, Provider shall be terminated from participating as a provider in any network of Health Plan that serves individuals eligible to receive Medicaid or CHP.

ATTACHMENT G

Medicare Advantage

Laws and Government Program Requirements

This attachment sets forth applicable Laws and Government Program Requirements, or other provisions necessary to reflect compliance for the Medicare Advantage Product. This attachment will be automatically modified to conform to subsequent changes to Laws or Government Program Requirements. All provisions of the Agreement not specifically modified by this attachment remain unchanged and will control. In the event of a conflict between this attachment and any other provision in the Agreement, the provisions in this attachment will control for the Medicare Advantage Product. Capitalized terms used in this attachment will have the same meaning ascribed to them in the Agreement unless otherwise set forth in this attachment. Any purported modification or any provision in this attachment that is inconsistent with a Law or Government Program Requirement will not be effective and will be interpreted in a manner that is consistent with the applicable Law and Government Program Requirement. This attachment only applies to Medicare Advantage Product.

1.1 **Downstream Compliance.** Provider agrees to require its Downstream Entities that provide any services benefiting Health Plan's Medicare Members to agree in writing to all of the terms provided herein.

1.2 **Right to Audit.** The United States Department of Health and Human Services ("HHS"), the Comptroller General, or their designees have the right to audit, evaluate, and inspect any pertinent information, including books, contracts, records, including medical records and documentation that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under Health Plan's contract with CMS, or as the Secretary may deem necessary to enforce Health Plan's contract with CMS. Provider agrees to make available, for the purposes specified in this paragraph, its premises, physical facilities and equipment, records relating to its Medicare Members, and any additional relevant information that CMS may require. HHS, the Comptroller General, or their designee's right to inspect, evaluate, and audit extends through ten (10) years from the end of the final contract period between Health Plan and CMS or completion of audit, whichever is later.

1.3 **Confidentiality.** Provider will comply with the confidentiality and Member record accuracy requirements set forth in 42 CFR 422.118.

1.4 **Hold Harmless/Cost Sharing.** Provider agrees it may not under any circumstances, including non-payment of moneys due to the provider by Health Plan, insolvency of Health Plan, or breach of this Agreement, bill, charge, collect a deposit, seek compensation, remuneration, or reimbursement from, or have any recourse against the Member, or any persons other than Health Plan acting on their behalf, for services provided in accordance with this Agreement. The Hold Harmless clause will survive the termination of this Agreement, regardless of the cause of termination. In addition, for Members who are dually eligible for Medicare and Medicaid and enrolled in a MA-SNP will not be held liable for Medicare Part A and B cost sharing when the State or another payer such as a Medicaid Managed Care Plan is responsible for paying such amounts. Health Plan will inform providers of applicable Medicare and Medicaid benefits and rules for eligible Members. Provider agrees to accept payment from Health Plan as payment in full, or bill the appropriate State source, for any Medicare Part A and B cost sharing that is covered by Medicaid. Collection from the Member of co-payments or supplemental charges in accordance with the terms of the Member's contract with Health Plan, or charges for services not covered under the Member's contract, may be excluded from this provision.

1.5 **Accountability.** Health Plan may only delegate activities or functions to a Downstream Entity in a manner that is consistent with the provisions set forth in Health Plan's delegated services agreement.

1.6 **Delegation.** Any services or other activity performed by a Downstream Entity in accordance with a contract or written agreement will be consistent and comply with the Health Plan's contract with CMS.

1.7 **Prompt Payment.** For the avoidance of doubt, prompt payment will be governed by Section 4.2, Compensation, in the Agreement. Health Plan reserves the right to deny any Claims that are not in accordance with the Medicare Claims Processing Manual and Medicare rules for billing.

1.8 **Reporting**. Provider agrees to provide relevant data to support Health Plan in complying with the requirements set forth in 42 CFR 422.516 and 42 CFR 422.310.

1.9 **Compliance with Medicare Laws and Regulations.** Provider will comply with all applicable Medicare Laws, regulations, and CMS instructions.

1.10 **Benefit Continuation**. Provider agrees to provide for continuation of Member health care benefits: (i) for all Members, for the duration of the period for which CMS has made payments to Health Plan for Medicare services; and (ii) for Members who are hospitalized on the date Health Plan's contract with CMS terminates, or, in the event of insolvency, through discharge.

1.11 **Cultural Considerations**. Provider agrees that services are provided in a culturally competent manner to all members, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds.

ATTACHMENT H

Medicare-Medicaid Program

Laws and Government Program Requirements

This attachment sets forth applicable Laws and Government Program Requirements, or other provisions necessary to reflect compliance for the MMP Product. This attachment will be automatically modified to conform to subsequent changes to Laws or Government Program Requirements. All provisions of the Agreement not specifically modified by this attachment remain unchanged and will control. In the event of a conflict between this attachment and any other provision in the Agreement, the provisions in this attachment will control for the MMP Product. Capitalized terms used in this attachment will have the same meaning ascribed to them in the Agreement unless otherwise set forth in this attachment. Any purported modification or any provision in this attachment that is inconsistent with a Law or Government Program Requirement will not be effective and will be interpreted in a manner that is consistent with the applicable Law and Government Program Requirement. This attachment only applies to MMP Product.

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ATTACHMENT I

Molina Marketplace

Laws and Government Program Requirements

This attachment sets forth applicable Laws and Government Program Requirements or other provisions necessary to reflect compliance for the Molina Marketplace Product. This attachment will be automatically modified to conform to subsequent changes to Laws or Government Program Requirements. All provisions of the Agreement not specifically modified by this attachment remain unchanged and will control. In the event of a conflict between this attachment and any other provision in the Agreement, the provisions in this attachment will control for the Molina Marketplace Product. Capitalized terms used in this attachment will have the same meaning ascribed to them in the Agreement unless otherwise set forth in this attachment. Any purported modification or any provision in this attachment that is inconsistent with a Law or Government Program Requirement will not be effective and will be interpreted in a manner that is consistent with the applicable Law and Government Program Requirement. This attachment only applies to Molina Marketplace Product.

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