CRYSTAL RUN HEALTH PLAN, LLC, AND CRYSTAL RUN HEALTH INSURANCE COMPANY, INC. PARTICIPATING ANCILLARY PROVIDER AGREEMENT

This agreement (the "Agreement"), effective August 1, 2018, is entered into by and among Crystal Run Health Plan, LLC and Crystal Run Health Insurance Company, Inc., each with a corporate address of 109 Rykowski Lane, Middletown, NY 10941 (hereafter referred to collectively as "Crystal Run"), and **Sullivan County Public Health Services** ("Ancillary Provider"), with an address of 50 Community Lane, PO Box 590, Liberty, NY 12754.

WHEREAS, Crystal Run Health Plan, LLC is a for-profit health maintenance organization certified under Article 44 of the New York State Public Health Law and Crystal Run Health Insurance Company, Inc. is a for-profit accident and health insurance company organized under Article 42 of the New York Insurance Law;

WHEREAS, each of the Crystal Run entities provides benefits for specified health care services furnished to persons enrolled under the various benefits plans that it issues;

WHEREAS, Ancillary Provider is a healthcare provider duly licensed and/or registered, as applicable, to provide Covered Services who, through its signature to this Agreement, agrees to participate in the various Health Benefit Programs underwritten or administered by Crystal Run; and

WHEREAS, Crystal Run and Ancillary Provider desire to enter into this Agreement under which Ancillary Provider will provide Covered Services to persons enrolled in specified Health Benefit Programs.

NOW THEREFORE, in consideration of the promises and mutual covenants set forth herein and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties mutually agree as follows:

1. DEFINITIONS

For purposes of this Agreement, the following definitions will apply:

(1) **"Claim"** means a statement of services submitted to Crystal Run, or its delegate, by Ancillary Provider following the provision of Covered Services to a Covered Person, which includes diagnosis(es) and an itemization of services and treatment rendered in a format acceptable to Crystal Run, or its delegate, and generally used by like Ancillary Providers for submitting such Claims.

(2) **"Clean Claim"** means an accurate (no erroneous or conflicting information) Claim that has no defect, impropriety, lack of required substantiating documentation or particular circumstance requiring special treatment that prevents timely payment, and contains all of the elements set forth in applicable Federal or State law or regulation including, but not limited to, 11 NYCRR Part 217, as amended from time to time.

(3) **"Covered Persons"** means those persons enrolled in a Health Benefit Program.

(4) **"Covered Services"** means those Medically Necessary healthcare services for which Payor provides benefits to, or on behalf of, Covered Persons enrolled in a Health Benefit Program, pursuant to the terms of that Health Benefit Program.

(5) **"Health Benefit Program(s)"** means the program(s) underwritten or administered by Crystal Run setting forth covered benefits provided to a Covered Person pursuant to a subscriber contract between the Payor and the Covered Person.

(6) "**Medically Necessary**" or "**Medical Necessity**" means health care services that an ancillary provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms that are: (i) in accordance with generally accepted standards of medical practice; (ii) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; (iii) not primarily for the convenience of the patient, physician, or other health care provider; and (iv) not more costly than an alternative service or series of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community and the views of Ancillary Providers practicing in relevant clinical areas.

(7) **"Participating Provider"** means a physician, allied health professional, ancillary provider or other professional duly licensed and/or registered in the State of New York who agrees to provide Covered Services to Covered Persons as part of the Crystal Run provider network for a Health Benefit Program.

(8) **"Payor"** means the entity that is legally responsible for payment of Covered Services under the terms of the Health Benefit Program. Payor will include (i) Crystal Run with respect to Crystal Run's fully insured business, and (ii) any self-funded customers who are entitled to access the network of Crystal Run.

2. PRACTITIONER OBLIGATIONS

A. **Covered Services**. Ancillary Provider agrees to provide Covered Persons with those Covered Services (i) that Ancillary Provider commonly performs, (ii) that are within the scope of Ancillary Provider's license and practice, and (iii) for which Ancillary Provider has been credentialed by Crystal Run, as more fully set forth on Exhibit A. Ancillary Provider agrees to render Covered Services to Covered Persons in the same manner, in accordance with the same standards, and with the same priority, as are provided to Ancillary Provider's other patients.

B. **Network Participation.** Ancillary Provider agrees to provide Covered Services to Covered Persons eligible for or enrolled in the Health Benefit Program(s) indicated on Exhibit A to this Agreement. In the event Crystal Run introduces any new Health Benefit Programs during the term of this Agreement, Ancillary Provider will be deemed to be participating with such new benefit plans upon Crystal Run's provision to Ancillary Provider of written notice at least sixty (60) days prior to implementation of such new Health Benefit Programs, which notice will set forth the terms of participation in such new Health Benefit Programs. Such prior notice will not be required for new Health Benefit Programs that differ only in cost-sharing variations from existing Health Benefit Programs. All such programs will be considered Health Benefit Programs under this Agreement. Crystal Run reserves the right, at all times, to determine, in its sole discretion, Ancillary Provider's

participation in any new Health Benefit Programs, and does not guarantee Ancillary Provider's participation in new Health Benefit Programs.

C. **Network Requirements**.

1. All non-emergent services provided in connection with Covered Services provided at Ancillary Provider's office(s), regardless of whether such non-emergent services are provided at Ancillary Provider's office or by referral, will be provided by Participating Providers subject to subparagraph 2, below. Non-emergent services include, but are not limited to, laboratory, anesthesia, and radiology services.

2. Ancillary Provider agrees that all referrals will be made to Participating Providers. The only exception to this will be when Ancillary Provider has obtained a written acknowledgement or waiver form from the Covered Person prior to the provision of a service indicating that (i) the Covered Person was advised that no coverage, or only out-of-network coverage, would be available from Crystal Run, and (ii) the Covered Person agreed to be financially responsible for the additional costs related to such service. Without limiting the generality of the foregoing, this subparagraph will also apply to services provided by non-participating assistant surgeons and anesthesiologists providing services at Ancillary Provider's request, or at Ancillary Provider's office location, in conjunction with services provided by Ancillary Provider hereafter.

3. Payor may require Ancillary Provider to obtain pre-certification for certain procedures, drugs, or other items provided in Ancillary Provider's office, or for the services of an assistant surgeon or anesthesiologist for procedures performed in the Ancillary Provider's office. Crystal Run's requirements are described in the Crystal Run Provider Manual, as updated from time to time. Complete and current versions of all Crystal Run policies and procedures referenced in this Agreement are available at www.crystalrunhp.com. If Ancillary Provider fails to obtain a required pre-certification for one of these procedures, drugs, or other items, or for the services of an assistant surgeon or anesthesiologist, Payor will be entitled to deny payment for such procedure, drug or other item.

4. Crystal Run may require that certain drugs administered in Ancillary Provider's office be obtained through a vendor designated by Crystal Run. Crystal Run will provide a list of such drugs to Ancillary Provider and will update such list from time to time. Non-self-administrated (NSA) Medications are medications which cannot be administered to the patient by the patient themselves or a caregiver, but rather must be administered by a health care professional. Beginning in January of 2018, NSA's will be covered under the medical benefit and no longer under the pharmacy benefit, with few exceptions. Ancillary Provider's will bill Crystal Run for the drug as well as the fee to administer the drug. Most NSAs will require a prior authorization. Ancillary Provider will not bill Covered Persons any amount for the cost of the drug. If Ancillary Provider obtains one of these drugs from a source other than Crystal Run's designated vendor, Crystal Run will be entitled to deny payment for such drug, and Ancillary Provider will not seek payment from the Covered Person.

5. Crystal Run may require evidence of completion of specific training as a pre-condition for reimbursing providers for certain diagnostic tests or procedures requiring specialized training, as specified in the Crystal Run Provider Manual. Ancillary Providers who do not

meet the stated requirements will not be eligible for reimbursement for performance of the diagnostic test or procedure and will not seek payment from the Covered Person. The only exception to this rule will be when Ancillary Provider has obtained a written acknowledgement from the Covered Person, prior to the provision of service(s), indicating that the Covered Person was advised that no coverage, or only out-of- network coverage, would be available from Crystal Run, and that the Covered Person agreed to be financially responsible for the additional costs related to such services.

6. The requirements of this Section 2(C) apply to all Health Benefit Programs Ancillary Provider participates in. If Ancillary Provider fails to adhere to the requirements set forth in this Section 2(C), Ancillary Provider may be subject to sanctions including, but not limited to, termination of this Agreement or otherpenalties.

D. **Credentialing and Recredentialing**. Ancillary Provider agrees to cooperate with Crystal Run's credentialing and recredentialing procedures, and hereby expressly authorizes Crystal Run to obtain information from third parties concerning the competence and conduct of the Ancillary Provider. Ancillary Provider represents that the information set forth in its application for network participation, or in any recredentialing form, is complete and accurate. Ancillary Provider agrees to immediately notify Crystal Run in writing in the event that (i) Ancillary Provider's license to practice in any state is revoked or suspended, (ii) Ancillary Provider is found by a court of competent jurisdiction or regulatory authority to have committed professional misconduct under applicable state law or regulation in any state in which Ancillary Provider has practiced, (iii) Ancillary Provider's DEA number is revoked, (iv) Ancillary Provider is sanctioned or excluded from the Medicare or any state's Medicaid Program(s), (v) Ancillary Provider is no longer authorized to render medical care under the Workers' Compensation Law, (vi) Ancillary Provider's privileges at any hospital are suspended or revoked, (vii) there is any change in Ancillary Provider's professional liability coverage, or (viii) in the opinion of a prudent health care provider there is an occurrence or event which makes Ancillary Provider unable to render medical services to Covered Persons in a high quality manner in compliance with the terms of this Agreement.

E. **Hospital Affiliation**. Where Ancillary Provider is a physician, (s)he will maintain an affiliation with at least one hospital in Crystal Run's provider network (referred to herein as a "Participating Hospital"), and will admit Covered Persons only to Participating Hospitals. Ancillary Provider will inform Crystal Run immediately in the event such affiliation with a Participating Hospital is discontinued.

F. **Quality Assurance/Utilization Review/Administrative Procedures**. Ancillary Provider agrees to comply fully with and abide by all applicable administrative rules, policies and procedures that Payor has established or will establish, including those pertaining to: quality management and improvement; utilization management, including but not limited to, pre- certification procedures, referral processes and protocols, and reporting of clinical encounter data; Covered Person grievances; credentialing and recredentialing; Claim reviews; appeals of Claim and utilization management determinations; and other administrative requirements, as amended and in effect from time to time. Complete descriptions of all of Crystal Run's programs, guidelines, policies, and procedures are contained in the Crystal Run Provider Manual, which is provided to all Participating Providers, and which is expressly incorporated herein by reference and made available at www.crystalrunhp.com. Crystal Run will provide Ancillary Provider with written notice of any material changes to such programs at least ninety (90) days prior to implementing such changes,

except in cases where law or regulation requires immediate implementation of any such change. Notwithstanding the foregoing, if Ancillary Provider objects to a material modification of the Crystal Run Ancillary Provider Manual, Ancillary Provider may provide written notice of Ancillary Provider's intent to terminate this Agreement as provided in Section 5(B) of this Agreement.

G. **Coverage Verification**. Prior to treating any individual who presents himself or herself as a Covered Person, Ancillary Provider will, in compliance with Payor's policies and procedures, verify such individual's eligibility as a Covered Person under the terms of the governing Health Benefit Program. Compliance with Payor's enrollment verification policies and procedures, and verification of eligibility by Payor, does not ensure that an individual is, in fact, a Covered Person, and eligible to receive Covered Services. In the event Payor subsequently determines that an individual was not eligible to receive Covered Services on the date of service, Payor will notify Ancillary Provider. Unless prohibited by applicable New York State law, Payor will be entitled to receive a full refund of all payments or allocations made by Payor to, or on behalf of, Ancillary Provider for such individual following the date of ineligibility, and Payor will have no liability to Ancillary Provider for services rendered to such individual on or after the date of ineligibility. Ancillary Provider may, however, seek compensation from such individuals for services rendered on or after the date of ineligibility.

H. **Pre-certification of Covered Services**. If Payor pre-certifies the Medical Necessity of a proposed Covered Service, Payor will not subsequently revoke the Medical Necessity determination unless: (i) the relevant information presented on concurrent or retrospective review is materially different that the information that was provided at the time of the pre-certification review; (ii) such information existed at the time of the pre-certification review but was not made available to Payor at that time; (iii) Payor was not aware of the existence of such information at the time of the pre-certification review; and (iv) the service would not have been approved as Medically Necessary if Payor had known the information at that time.

I. **Multiple Office Sites**. Ancillary Provider understands and agrees that this Agreement constitutes Ancillary Provider's agreement to participate in Crystal Run's provider network at all of Ancillary Provider's office sites listed in Appendix A. Ancillary Provider is hereby prohibited from restricting participation to certain office locations when Ancillary Provider maintains multiple offices. Ancillary Provider will provide thirty (30) days advance written notice of the addition or deletion of any Ancillary Provider office sites.

J. **Non-Discrimination**. Ancillary Provider agrees to accept Covered Persons as patients without regard to an individual patient's health history or current health status, and without discrimination against Covered Persons on the basis of source of payment, gender, age, race, color, creed, sexual orientation, religion, marital status, place of origin, economic status, enrollment in state or federal entitlement program, medical diagnosis, or disability. Ancillary Provider reserves the right to not accept any new Covered Persons if Ancillary Provider determines that its patient load is at capacity, and Ancillary Provider has stopped accepting new patients across its practice, regardless of source of payment; provided, however that a primary care physician will permit existing patients who were not previously enrolled in a Health Benefit Program, but who subsequently do enroll in a Health Benefit Program, to designate Ancillary Provider as their primary care physician. Ancillary Provider must provide one hundred twenty (120) days prior written notice to Crystal Run if Ancillary Provider elects to not accept additional Covered Persons.

K. **Records**. Ancillary Provider will maintain adequate medical, financial and administrative records for all Covered Services provided to Covered Persons and assure that all such records are available, without charge, for purposes of reviewing the appropriateness and quality of services

provided, as required by law, and in connection with Payor's Claim, utilization review, quality assurance, peer review and grievance activities, without charge, upon request of (i) Payor or its designee, and (ii) the New York State Department of Health (the "Department of Health") and other appropriate government authorities. Ancillary Provider will also provide to Payor, and to appropriate State and Federal regulatory authorities, upon request and without charge, financial data and reports, and information. Ancillary Provider will retain records for six (6) years after the date of service and, in the case of minors, until six (6) years after the age of majority, or for such longer period as may be required by applicable law and regulation. Upon reasonable notice, Ancillary Provider will also allow Payor, its authorized representatives and designees, and duly authorized third parties such as government or regulatory agencies, access to Ancillary Provider's practice site(s) during regular business hours to conduct site visits and otherwise inspect, review and receive copies of records related to services provided to Covered Persons. Payor will only make payment for Covered Services which are documented in a Covered Person's medical record. Ancillary Provider will cooperate with any request for additional information to document the Medical Necessity of a particular service. Ancillary Provider acknowledges that failure to provide such documentation within reasonable timeframes established by Payor will be grounds for denial of the Claim for such service. Ancillary Provider will use its best efforts to obtain any necessary releases from Covered Persons with respect to their records and the disclosure of information contained therein. Payor and its designees, and Ancillary Provider will comply with all State and Federal laws regarding confidentiality of patient records. In addition, Ancillary Provider will comply with the confidentiality restrictions of Public Health Law Article 27-F and Section 2784, dealing with patient- specific information related to HIV infection. This Section 2(K) will survive termination of this Agreement for any reason.

L. **Insurance**. Ancillary Provider will maintain professional liability insurance in the minimum amount of one million dollars ($1,000,000) per occurrence, and three million dollars ($3,000,000) in the annual aggregate. In the event any such policy is a claims made policy, Ancillary Provider will, prior to the termination of such policy, procure (i) a replacement policy or policies, in the same coverage amounts as specified above, with retroactive dates no later than the effective date of this Agreement, and/or (ii) purchase unlimited "tail" insurance coverage in the same coverage amounts as specified above, effective on the date of termination of such "claims made" policy, and maintain such replacement or tail coverage for a period of six (6) years after termination of the claims made policy, so that continuous insurance coverage in the above amounts is provided, with no gaps in coverage regardless of whether a claim is asserted during the term of this Agreement or thereafter. Ancillary Provider will immediately notify Crystal Run of any changes to the insurance coverage maintained by Ancillary Provider, and will provide a certificate of insurance coverage to Crystal Run upon request. Ancillary Provider further agrees to provide Crystal Run thirty (30) days prior written notice of cancellation or termination of any such insurance policies.

3. RELATIONSHIP BETWEEN PARTIES

A **Independent Contractor**. Crystal Run and Ancillary Provider are independent legal entities. Nothing in this Agreement will be deemed to create between Crystal Run and Ancillary Provider any relationship of employer and employee or of principal and agent, or any partnership, joint venture or other association. In performing services under this Agreement, Ancillary Provider is, and will act at all times and in all respects as, an independent contractor.

B. **Ancillary Provider's Responsibility for Medical Services**. Ancillary Provider will be solely responsible for the creation and maintenance of the Ancillary Provider/patient relationship with Covered Persons and for all decisions regarding Covered Persons' healthcare. Ancillary Provider understands that Claim and utilization review decisions made by Payor are for the purposes of determining whether services are Covered Services. Such decisions will in no way affect Ancillary Provider's responsibilities to provide care in a manner consistent with sound medical judgment and practice. Nothing contained herein will be construed to require Ancillary Provider to take any action inconsistent with its professional judgment regarding a Covered Person's care. Furthermore, nothing in this Agreement, or in any of Payor's guidelines, policies or procedures is intended to, or will be deemed to, limit or restrict Ancillary Provider's ability to communicate openly with Covered Persons regarding their medical care, including the discussion of any treatment alternatives. Ancillary Provider will not be penalized for discussing the Medical Necessity or appropriateness of a service with a Covered Person or with Payor, or for making a report or complaint to a governmental body regarding a particular incident, or Payor's guidelines, policies or procedures, in general.

4. BILLING AND COMPENSATION

A. **Compensation**. Subject to any reductions described in Section 4(B) below, and any reductions based on Payor's payment or medical management policies, Payor will compensate Ancillary Provider for Medically Necessary Covered Services provided to Covered Persons in accordance with Exhibit B to this Agreement. Such amounts will be accepted by Ancillary Provider as payment in full for Covered Services; Ancillary Provider will not, under any circumstances, balance bill a Covered Person for a Covered Service. Ancillary Provider will not bill or otherwise attempt to collect from a Covered Person the charge for any service which Crystal Run deems included in the fee amount payable to Ancillary Provider pursuant to Exhibit B.

Notwithstanding the foregoing, Crystal Run may enter into agreements with other providers for the payment of discounted rates for certain services that Ancillary Provider may also render. When Ancillary Provider is permitted by Crystal Run to perform such Covered Services, the amount payable, subject to deductibles, coinsurance, co-payments and visit fees will be the lesser of: (i) Ancillary Provider's actual charge; or (ii) the lowest rate payable by Crystal Run pursuant to any such agreement(s) in the area where the service is rendered.

Complete and up-to-date versions of all Crystal Run fee schedules are accessible through Crystal Run's internet provider portal at www.crystalrunhp.com, and are hereby incorporated by reference. Ancillary Providers who do not have access to the internet may submit a list of the codes for services within their specialty, and Crystal Run will provide a printed list of the associated fee schedule(s). Upon Ancillary Provider's written request, Crystal Run will attach any such fee schedule(s) to this Agreement, which will be incorporated by reference and binding upon Ancillary Provider. Crystal Run will provide written notice to Ancillary Provider at least ninety (90) days prior to the effective date of any adverse changes to any applicable fee schedules, other than any changes made in order to (i) reflect changes in market prices for vaccines, injectables, pharmaceuticals, durable medical supplies, other goods, and non-physician services, (ii) to add payment rates for newly-adopted CPT® Codes, and/or (iii) to add payment rates for new technologies and new uses of established technologies that Crystal Run determines, in its sole and absolute discretion, are eligible for payment under this Agreement.

If Ancillary Provider provides radiology, pathology, diagnostic cardiology, or emergency room services at a Participating Hospital which has agreed to accept a global rate for the technical and professional components of such care, Ancillary Provider will look solely to such Participating Hospital for compensation for such Covered Services, and expressly acknowledges that Ancillary Provider will have no claim against Payor, Payor's group accounts, or the Covered Person for reimbursement for such Covered Services. If the Participating Hospital has not agreed to a global rate for such services, Ancillary Provider will be reimbursed for the professional component of such Covered Services according to the terms of this Section 4(A).

B. **Reductions in Compensation**. Crystal Run's payments to Ancillary Provider will be reduced by the following, when applicable:

(1) **Cost-Sharing Amounts**. The Health Benefit Programs may require Covered Persons to pay deductibles, coinsurance, copayments or visit fees for certain Covered Services, which requirements may differ among Covered Persons. Whenever Ancillary Provider provides Covered Services for which a permitted deductible, coinsurance, copayment or visit fee is due, Ancillary Provider will collect and retain the deductible, coinsurance, copayment or visit fee. The amount payable by the Covered Person, when added to the amount payable by Payor, will not exceed the lesser of Ancillary Provider's actual charge or the amount set forth in the applicable Fee Schedule, or as otherwise allowed under this Agreement.

(2) **Ancillary Provider Penalties; Right to Set-Off**. Payor will deduct from its payments to Ancillary Provider the amount of any applicable Ancillary Provider penalties under Payor's utilization/medical management programs or other terms of this Agreement. Ancillary Provider will accept the applicable rates described in Section 4(A) above, reduced by any applicable penalties under this subparagraph (2), as payment in full, and will not pursue payment for the amount of the penalty from the CoveredPersons.

(3) **Site of Service Reduction**. To the extent applicable, Ancillary Provider may be subject to a reimbursement reduction (i.e., site of service differential) for selected procedure codes as set forth in the Crystal Run Ancillary Provider Manual when the service is performed in a hospital inpatient, outpatient, emergency room, or ambulatory surgery facility. The reduction percentage is based on the Resource Based Relative Value Scale (RBRVS) calculation of the physician overhead cost component, and reflects the fact that when the procedure is performed in the facility setting the provider uses hospital materials rather than incurring their own expenses.

C. **Hold Harmless**. Except as expressly provided in Section 4(D) below, Payor is the sole party responsible for payment of compensation to Ancillary Provider for providing Covered Services to Covered Persons. Ancillary Provider agrees that in no event, including, but not limited to, nonpayment by Payor, insolvency of Payor, or breach of this Agreement, will Ancillary Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against, a Covered Person or person (other than Payor) acting on a Covered Person's behalf, for services provided pursuant to this Agreement and the terms of the applicable Health Benefit Program in effect on the date of service. However, this provision will not prohibit Ancillary Provider from collecting any permitted deductible, coinsurance, copayment, visit fees or

penalties which may be described in the Health Benefit Programs, copies of which will be made available at www.crystalrunhp.com.

Ancillary Provider may also collect fees for uncovered services, delivered on a fee-for-service basis to a Covered Person, provided that prior to rendering the service Ancillary Provider will have advised the Covered Person, and will have obtained from the Covered Person a signed written acknowledgement, that the service is uncovered and that the Covered Person is financially liable therefor. When Ancillary Provider has not been given a list of Covered Services by Payor, and/or Ancillary Provider is uncertain whether a service is covered, Ancillary Provider will make reasonable efforts to contact Payor and obtain a coverage determination prior to advising the Covered Person as to coverage and liability for payment and prior to providing theservice.

Ancillary Provider will not bill or otherwise attempt to collect from Covered Persons the amount of any benefit denied or reduced due to Payor's utilization/medical management activities.

This Section 4(C) will survive termination of this Agreement for any reason, and will supersede any oral or written agreement now existing or hereafter entered into between Ancillary Provider and a Covered Person or person acting on Covered Person's behalf.

D. **Self-Insured Health Benefit Programs**. Payments for services covered under self-insured Health Benefit Programs are the ultimate responsibility of Payor's group customer. Crystal Run will not make payments to Ancillary Provider on behalf of their self-funded customers unless the group customer has provided Payor with sufficient funds to make such payments. In the event a self-funded customer fails to fund its account, Ancillary Provider will have the right to seek payment from the self-funded customer or the Covered Person.

E. **Coordination of Benefits**. Ancillary Provider agrees to conduct coordination of benefits ("COB") efforts in accordance with the policies and procedures established by Payor for the applicable Health Benefit Program. Ancillary Provider will not bill Covered Persons for any portion of a Covered Service not paid by the primary payor when Payor is the secondary payor, but will look solely to Payor for such payment. All amounts recovered through COB activities hereunder will become the property of Payor.

F. **Billing Procedures**. Ancillary Provider will submit a Clean Claim directly to Crystal Run in accordance with this Agreement, the Crystal Run Ancillary Provider Manual, and such other written materials as may be made available to Ancillary Provider from time to time. Claims will be submitted on the HCFA 1500 form, if in paper format, or such other acceptable format approved or required by Crystal Run, such as electronic Claim submission, diskette or tape. All Claims must be received by Crystal Run within one hundred twenty (120) days of the later of: (i) the date of service; or (ii) the date of Ancillary Provider's receipt of an Explanation of Benefits ("EOB") from the primary payor, where Payor is the secondary payor. The date of receipt will be considered: (a) with respect to Claims or information delivered by the United States Postal Service or other delivery service, the date of delivery at the insurer, corporation or organization; or (b) with respect to Claims or information delivered electronically, the date of electronic acknowledgement from Crystal Run, which can be accessed through Crystal Run's provider portal. In the event of a dispute, Ancillary Provider will be obligated to provide proof of Crystal Run's receipt, such as a return receipt from the United States Postal Service, or an electronic validation report from Crystal Run. If a Claim has been submitted electronically, but no validation report was provided indicating that the Claim has

been accepted, the Claim has not been received by Crystal Run, and it is Ancillary Provider's responsibility to contact Crystal Run to determine and correct any error preventing its receipt by Crystal Run, and/or to submit a paper Claim.

Payor will not make payment on any Claim that is not received by Crystal Run within the timeframes described in this Section 4. This requirement will not apply to any Claim submission which could not be completed in a timely manner due to error or omission attributable to Crystal Run. In addition, Crystal Run may, in its sole discretion, extend the applicable filing deadline for a reasonable period, on a case by case basis, in the event Ancillary Provider provides notice to Crystal Run, along with appropriate evidence of circumstances beyond Ancillary Provider's control that resulted in the delayed submission. Ancillary Provider will not bill Covered Persons for any Covered Services for which Ancillary Provider has failed to submit a bill or Claim to Crystal Run in a timely manner as described above.

G. **Claims Payment**. Upon receipt of a Clean Claim, including any necessary authorization, for which payment is due under the Covered Person's Health Benefit Program, Payor will make payment directly to Ancillary Provider. Payments will be made in accordance with any applicable State or Federal statute or regulation governing the timely payment of healthcare benefit claims, including but not limited to the provisions of New York State Insurance Law Section3224-a.

H. **Refunds**. In the event that, through error, Payor makes any payment to Ancillary Provider for services to Covered Person not due to be paid hereunder, or under the subscriber contract, Ancillary Provider will promptly refund such payment to Payor, or will, at Payor's option, permit any amount paid in error to be deducted from future Claims payments for Covered Services furnished to that or any other Covered Person. In accordance with this Section 4(H), Ancillary Provider will repay to a Covered Person, promptly upon discovery, the amount of any erroneous payments or overpayments made by such Covered Person to AncillaryProvider.

Other than for recovery of duplicate payments or other similar adjustments including those relating to (i) Claims where Ancillary Provider has received payment for the same services from another payor whose obligation is primary, or (ii) timing or sequence of Claims for the same Covered Person that are received by the Payor out of chronological order in which the services were performed, Payor will provide thirty (30) days advance written notice to Ancillary Provider before initiating any offset to recover overpayments. If Ancillary Provider requests an appeal within thirty (30) days of a request for repayment of an overpayment, Payor will not require repayment until the appeal has been completed. All claims for overpayments or underpayments made by either party must be made within eighteen (18) months of the date of the Ancillary Provider's receipt of the original payment; provided however, that unless otherwise expressly limited by applicable Federal or State law, no time limit will apply to the initiation of overpayment recovery efforts: (a) based on reasonable belief of fraud or other intentional misconduct; (b) required by a self-insured group customer; or (c) required by a Federal or State government program.

I. **Appeals and Reconsiderations**. Any Action by Crystal Run in paying or denying payment on claims shall be considered final unless provider submits an appeal in writing within 45 days from the explanation of payment (EOP). Appeals must be submitted in writing using Crystal Run's claims reconsideration request form. Failure to submit an appeal within the 45 days will result in the appeal being denied. Crystal Run will only accept the EDI Acceptance Journal as proof of timely filing for electronic claims submission.

5. TERM AND TERMINATION

A. **Term and Renewal**. This Agreement will remain in effect until the next January 1 following the Effective Date, at which time it will automatically renew for a term of one calendar year. Thereafter, this Agreement will automatically renew for an additional term of one calendar year as of each succeeding January 1, unless either party gives written notice of nonrenewal to the other party at least (60) days prior to the start of the next calendar year, or this Agreement is terminated as described below.

B. **Termination**. In addition to non-renewal of the Agreement as described above, this Agreement may be terminated as follows:

(1) Upon Prior Notice. Ancillary Provider or Crystal Run may terminate this Agreement, with or without cause, by providing sixty (60) days prior written notice to the other party. If this Agreement is terminated for cause by Crystal Run in this manner, Crystal Run will provide Ancillary Provider with a written explanation of the reasons for the proposed termination, and an opportunity to request a hearing or review, as required by law.

(2) Without Prior Notice. This agreement may be terminated immediately by Crystal Run in the event Crystal Run determines that (i) Ancillary Provider's continued treatment of Covered Persons poses an imminent threat of harm to such Covered Persons; (ii) Crystal Run or any court of competent jurisdiction, regulatory body, or law enforcement agency determines that Ancillary Provider has engaged in any type of fraudulent activity; (iii) Crystal Run discovers that the Ancillary Provider has been the subject of a final disciplinary action by an appropriate governmental authority that impairs Ancillary Provider's ability to practice; or (iv) upon learning that Ancillary Provider has been excluded from any Federal or State government sponsored health care program
Crystal Run will comply with all applicable Federal and State statutes and regulations governing provider terminations.

C. **Continured Care**. In the event this Agreement is terminated, the delivery of written notice of intent to terminate will not excuse Ancillary Provider from continuing to treat Covered Persons prior to the effective date of such termination, or from cooperating in the orderly transfer of Covered Persons and copies of their medical records to other providers participating in the appropriate Health Benefit Program. Ancillary Provider agrees that, except as otherwise required by statue or regulation, in the event of Crystal Run's insolvency or the termination of this Agreement for any reason, Ancillary Provider will continue to provide Covered Services to Covered Persons who were confined in an inpatient facility or were engaged in receiving a course of treatment at the time this Agreement was terminated. Ancillary Provider will continue to provide medically appropriate care to such Covered Person until medically appropriate discharge or transfer, or completion of the course of treatment, whichever first occurs. Ancillary Provider will be paid for such services, to the extent that they would be Covered Services, at the same rates applicable immediately prior to the termination of this Agreement. Notwithstanding the foregoing, in the event Crystal Run is unable to transfer the Covered Person's care to another Participating Ancillary Provider due to geographic or travel-time barriers, or contractual restrictions, Ancillary Provider will

continue to accept, throughout the continued course of care, the same rates applicable immediately prior to the termination of this Agreement. Ancillary Provider continues to be responsible for ensuring Covered Person's eligibility during such continuity of care periods, including coverage verification. This provision will survive the termination of this Agreement for any reason.

6. MISCELLANEOUS

A. **Amendments**. Crystal Run may amend this Agreement unilaterally. Crystal Run will notify Ancillary Provider in writing of any such amendment at least ninety (90) days prior to the effective date of the amendment. The amendment will become effective, unless Ancillary Provider provides Crystal Run with a written notice of intent to terminate the Agreement pursuant to Section 5 above, prior to the effective date of the amendment. Notwithstanding the foregoing, Crystal Run may amend this Agreement effective immediately upon written notice to Ancillary Provider in order to comply with Federal, State or local laws or regulations. This Agreement may also be amended by a writing signed by the parties. Any material amendment will be subject to prior approval of the Department of Health, and any such amendment must be submitted for approval at least thirty (30) days in advance of its anticipated effective date.

B. **Notices**. Notice of termination of this Agreement shall be in writing in a method requiring written confirmation of receipt and shall be effective upon receipt. All other notices required under this Agreement shall be in writing and shall be deemed effective upon receipt if delivered personally, on the next business day after being sent via Federal Express or other nationally recognized overnight courier service, or five (5) calendar days after the date mailed postage prepaid to, or delivered personally at, the addresses set forth below::

If to Crystal Run:
Crystal Run Health Plan, LLC
Crystal Run Health Insurance Company,
Inc. 155 Crystal Run Road
Middletown, NY 10941
Attn: Chief Legal Officer

CC:
Crystal Run Health Plans
109 Rykowski Lane
Middletown, NY 10941
Attn: Executive Director

If to Ancillary Provider:
Sullivan County Public Health Services
PO Box 590
Liberty, NY 12754

Notwithstanding the foregoing, Crystal Run shall have the right to provide notice via e-mail where formal notice is not required.

C. **Regulatory Compliance**. Notwithstanding any other provision of this Agreement to the contrary, Crystal Run and Ancillary Provider will comply with the provisions of New York State's Managed Care Reform Act of 1996 (Chapter 705 of the Laws of 1996) and all amendments thereto; the Federal Americans With Disabilities Act; and any other applicable State or Federal statute or regulation governing the subject of this Agreement. Ancillary Provider will ensure that Ancillary Provider and Ancillary Provider's office staff comply with all local, Federal and State laws and regulations applicable to Ancillary Provider's practice, including, but not limited to, those prohibiting Ancillary Provider from making referrals for certain medical services to a provider or facility in which Ancillary Provider or an immediate family member has a financial interest or relationship.

Enrollment in NYS Medicaid Program. If Provider furnishes items and services to, or orders, prescribes, refers or certifies eligibility for, services for individuals eligible to receive Medicaid and Child Health Plus ("CHP"), Provider agrees to enroll in the NYS 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 NYS Medicaid Program, provider shall be terminated from participating as a provider in any network of the MCO that serves individuals eligible to receive Medicaid or CHP.

D. **Regulatory Approval**. The Department of Health "Standard Clauses" for HMO and IPA Ancillary Provider Contracts, attached to this Agreement as Exhibit C, are expressly incorporated into this Agreement and are binding upon the parties to this Agreement. In the event of any inconsistent or contrary language between the Standard Clauses and any other part of this Agreement, including but not limited to appendices, amendments and exhibits, the provisions of the "Standard Clauses" shall prevail. Crystal Run and Ancillary Provider acknowledge that this Agreement is subject to approval of the Department of Health and, if implemented prior to such approval, the parties agree to incorporate into this Agreement any and all modifications required by the Department of Health for approval or, alternatively, to terminate this Agreement effective sixty (60) days after such notice, subject to New York State Public Health Law Section 4403(6)(e), if so directed by the Department of Health. In the event any such approval is denied, or is conditioned upon certain changes hereto, Crystal Run shall revise this Agreement to the extent necessary to obtain regulatory approval, subject to Ancillary Provider's termination rights herein.

If Ancillary Provider participates in a Medicare-sponsored benefit plan, Exhibit D, attached hereto and made a part hereof, sets forth certain additional terms and conditions of participation specific to services rendered by Ancillary Provider to Covered Persons enrolled under a Medicare-sponsored benefit plan ("Medicare Members").

E. **Entire Agreement**. This Agreement supersedes any prior operating contracts, affiliation agreements, Letters of Agreement, Letters of Intent, Memoranda of Understanding, any equivalent document or other participation agreements between Ancillary Provider and Crystal Run to the extent that such prior agreements apply to services rendered to Covered Persons.

F. **Assignment**. This Agreement may not be assigned by Ancillary Provider without Crystal Run's prior written consent, and any such assignment absent such consent will be void. Crystal Run will be entitled to assign this Agreement, in whole or in part, to a parent, affiliate or subsidiary corporation or to a transferee of all or substantially all of Crystal Run's assets. Any such assignment will be effective immediately upon written notice to Ancillary Provider.

G. **Ancillary Provider Listings**. Ancillary Provider agrees to permit the use of its name in all published Crystal Run materials including, but not limited to, the Crystal Run directory of Participating Providers.

H. **Confidentiality**. Ancillary Provider agrees to treat as confidential this Agreement (including specifically, the terms of reimbursement and the applicable fee schedules), all provider and Covered Person listings, utilization data, reports and procedures, quality improvement procedures,

credentialing procedures, and all other procedures, programs, and protocols of Crystal Run. Ancillary Provider agrees not to disclose any such information to anyone unless that disclosure is authorized in writing by Crystal Run or required by applicable law. This section will survive the termination of this Agreement.

I. **Governing Law and Venue**. Ancillary Provider agrees that the laws of the State of New York will govern all matters relating to the validity, performance, and interpretation of this Agreement and that any action with respect to this Agreement will be solely and exclusively brought and tried in a court of competent jurisdiction in Orange County, New York.

J. **Grievances and Appeals.** Ancillary Provider will notify Crystal Run of any grievances received from Covered Persons and will cooperate with Crystal Run in the investigation and resolution of all grievances and appeals received by Crystal Run.

K. **Severability**. If any provision of this Agreement shall be or become invalid under any provision of Federal, State, or local law or regulation, or by a court of competent jurisdiction, the validity or enforceability of other provisions shall not be affected.

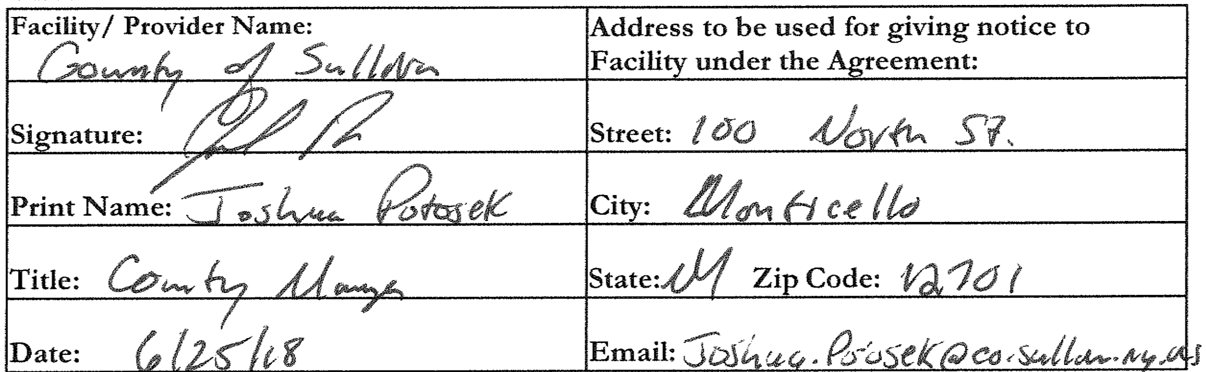
L. **Waiver**. No failure on the part of any party hereto to exercise, and no delay in exercising, any right, power or remedy hereunder will operate as a waiver thereof, nor will any single or partial exercise of any right, power or remedy hereunder preclude any other or further exercise thereof, or the exercise of any other right, power or remedy.

M. **Non-Exclusivity**. The parties' relationship is not exclusive. Either party may enter into similar arrangements with other entities provided that such arrangement does not prevent such party from fulfilling its obligations hereunder.

N. **Dispute Resolution**. If any dispute arises out of or relates to this Agreement, Ancillary Provider will follow any applicable Crystal Run practitioner appeal procedure if one exists, related to the subject matter of the dispute. If such appeal fails to resolve the dispute, or there is not a relevant Ancillary Provider appeal procedure for the subject matter involved, Crystal Run and Ancillary Provider will meet to attempt to resolve the dispute. If such efforts are unsuccessful, the only remedy either party has to resolve such dispute is through arbitration. Either party may commence arbitration by filing an arbitration demand with the American Health Lawyers Association ("AHLA") within twenty (20) days of such meeting. Notwithstanding the foregoing, in no event will the demand for arbitration be made after the date when institution of legal or equitable proceedings based on such dispute would be barred by the applicable statute of limitations.

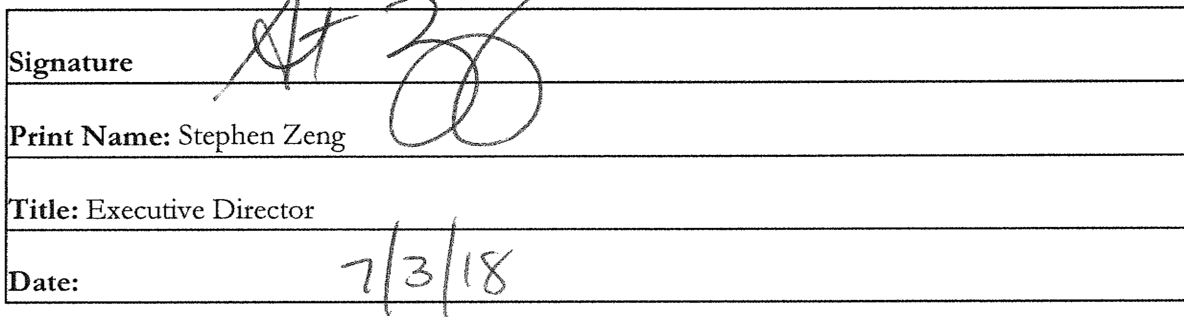
The dispute will be resolved through arbitration in the city and state where Crystal Run's offices are located, and each party will bear all of its own costs related to such arbitration. Notwithstanding the foregoing, the parties agree to the following in regards to arbitration: (i) multiple members on the arbitration panel are not required, and (ii) an arbitration proceeding cannot occur more than fifty (50) miles from the principal office of the Ancillary Provider. In addition, arbitration will not: (a) prevent the recovery of any statutory or otherwise legally available damages or other relief in an arbitration proceeding, (b) restrict the statutory or otherwise legally available scope or standard of review, (c) completely prohibit discovery, and (d) shorten any statute of limitations.

THIS AGREEMENT CONTAINS A BINDING ARBITRATION PROVISION THAT MAY BE ENFORCED BY THE PARTIES.



Facility/ Provider Name: County of Sullivan	**Address to be used for giving notice to Facility under the Agreement:**
Signature:	**Street:** 100 North St.
Print Name: Joshua Potosek	**City:** Monticello
Title: County Manager	**State:** NY **Zip Code:** 12701
Date: 6/25/18	**Email:** Joshua.Potosek@co.sullivan.ny.us

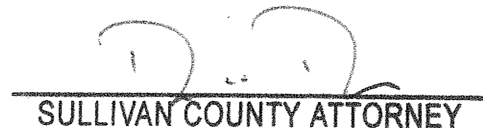
Crystal Run Health Plan and Crystal Run Health Insurance Company as signed by its authorized representative:



Signature
Print Name: Stephen Zeng
Title: Executive Director
Date: 7/3/18

[Address to be used for giving notice to Crystal Run under the Agreement] Street 109 Rykowski Lane City Middletown State NY Zip Code 10941
For Plan Use Only: Month and year in which agreement is first effective:

APPROVED AS TO FORM:



SULLIVAN COUNTY ATTORNEY

Appendix A
Facility Location and Service Listings

Ancillary Provider attests that this Appendix identifies all services and locations covered under this Agreement. IMPORTANT NOTE: Facility acknowledges its obligation to promptly report any change in Facility's name or Taxpayer Identification Number. Failure to do so may result in denial of claims or incorrect payment.

BILLING ADDRESS

Facility Name: Sullivan County Public Health Services
Street Address: PO Box 590
City: Liberty State: NY Zip: 12754
Tax ID Number (TIN): 14-6002812
National Provider ID (NPI): 1770639445

FACILITY LOCATIONS (complete one for each service location)		
Facility Name	**Facility Name**	**Facility Name**
Sullivan County Public Health Services		
Street Address	**Street Address**	**Street Address**
50 Community Lane		
City	**City**	**City**
Liberty		
State and Zip Code	**State and Zip Code**	**State and Zip Code**
NY 12754		
Phone Number	**Phone Number**	**Phone Number**
845-292-5910		
TIN (*If different from above*)	**TIN (*If different from above*)**	**TIN (*If different from above*)**
National Provider ID (NPI)	**National Provider ID (NPI)**	**National Provider ID (NPI)**

OTHER SERVICE LOCATIONS		
Facility Name	**Facility Name**	**Facility Name**
Street Address	**Street Address**	**Street Address**
City	**City**	**City**
State and Zip Code	**State and Zip Code**	**State and Zip Code**
Phone Number	**Phone Number**	**Phone Number**
TIN (*If different from above*)	**TIN (*If different from above*)**	**TIN (*If different from above*)**
National Provider ID (NPI)	**National Provider ID (NPI)**	**National Provider ID (NPI)**

EXHIBIT A
NETWORKS COVERED BY THIS AGREEMENT

Ancillary Provider shall be considered participating in each of the benefit plans listed below.

Crystal Run Health Plan

- Medicaid
- Essential Health Plan
- Child Health Plus
- Commercial HMO
  - Small Group Certificate
    - Platinum
    - Gold
    - Silver
    - Bronze
  - Individual Contract
    - Platinum
    - Gold
    - Silver
    - Bronze
  - Child Only Contract
    - Platinum
    - Gold
    - Silver
    - Bronze
  - Large Group Certificate

Crystal Run Health Insurance Company

- Small Group Certificate
  - Exclusive Provider Organization(EPO)
    - Platinum
    - Gold
    - Silver
    - Bronze
  - Preferred Provider Organization (PPO)
    - Platinum
    - Gold
- Large Group Certificate
  - Exclusive Provider Organization(EPO)
  - Preferred Provider Organization (PPO)

EXHIBIT B
COMPENSATION

1. Commercial, Subsidized HIX, Medicaid Membership (TANF, SSI, CHP, EHP: 100% of then current New York State assigned rate sheet.

> * Provider agrees to furnish a copy of their NYS assigned rate to CRHP within 30 days of receipt from NYS. At which time, CRHP will have 15 days to update providers profile with applicable rate. CRHP will only activate with the state assigned effective date if the document is received within 30 days as noted above with no interest applied. If CRHP receives the rate sheet outside of the time-frames noted above, it will be loaded within 15 days using the date received as the effective date of the rate for services. No retro claims adjustments will be available if the rate is not received within the 30 days' time-frame.

In the event there is not an amount provided for the Medicare Plan, Provider agrees to accept 100% of the then current Crystal Run Fee Schedule as payment in full.

In the event there is not an amount provided for the Medicaid Plan, Provider agrees to accept 100% of the then current Crystal Run Fee Schedule as payment in full.

Crystal Run shall make coding or rate changes to applicable Fee Schedules within 120 days of such changes becoming available or published by Medicaid or Medicare.

Crystal Run shall reimburse and Provider agrees to accept the lesser of 100% of Provider billed charges or the applicable fee schedule as noted above.

Crystal Run uses industry standard claims editing software for all claims processing. Crystal Run shall process all claims according to the CMS and NCCI policies and guidelines. All applicable edits will be applied.

EXHIBIT C
NEW YORK STATE DEPARTMENT OF HEALTH

STANDARD CLAUSES
FOR MANAGED CARE PROVIDER/IPA CONTRACT

(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 Appendix

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

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

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

B. General Terms and Conditions

1. This agreement is subject to the approval of the New York State Department of Health (DOH) and if implemented prior to such approval, the parties agree to incorporate into this Agreement any and all modifications required by DOH for approval or, alternatively, to terminate this Agreement if so directed by DOH,

effective sixty (60) days subsequent to notice, subject to Public Health Law §4403 (6)(e). This Agreement is the sole agreement between the parties regarding the arrangement established herein.

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

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

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

   - 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 ofpayment 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 callservice 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 nothingwithin this Agreement is intended to, or shall be deemed to, transfer liability for theMCO'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 Carecontract.

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

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

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

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

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

    g. The Provider or IPA/ACO agrees, pursuant to 31 U.S.C. §1352 and CFR Part 93, that no federally appropriated funds have been paid or will be paid to any person by or on behalf of the Provider/IPA/ACO for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of any Member of Congress in connection with the award of any federal

loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement. The Provider or IPA/ACO agrees to complete and submit the "Certification Regarding Lobbying," Appendix_ attached hereto and incorporated herein,if this Agreement exceeds $100,000. If any funds other than federally appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of a member of Congress, in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant loan, or cooperative agreement, and the Agreement exceeds $100,000 the Provider or IPA/ACO shall complete and submit Standard Form-LLL "Disclosure Form to Report Lobbying," in accordance with itsinstructions.

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 grantprograms).

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 relationshipinformation.

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-monthperiod 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 suchrequest.

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 theMCO.
  - All claims submitted for payment by the Provider/IPA/ACO are for care, services or medical supplies that have beenprovided.

- Payment requests are submitted in accordance withapplicable 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 thesubcontractor requests payment under the subcontract, acknowledgingthat:

☐ 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 theMCO.

☐ All claims submitted for payment by the subcontractor are forcare, services or medical supplies that have been provided.

☐ Payment requests are submitted in accordance withapplicable law.

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

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

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

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

C. Payment and Risk Arrangements

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

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

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

(CPT) codes, reporting guidelines and conventions; or such change is expressly provided for under the terms of this Agreement by the inclusion or reference to a specific fee or fee schedule, reimbursement methodology, or payment policy indexing scheme.

4. The parties agree to comply with and incorporate the requirements of Physician Incentive Plan (PIP) Regulations contained in 42 CFR §438.6(h), 42CFR §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 thereason.

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 enrolleeif 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 thereasons

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.

APPENDIX C-1
CERTIFICATION REGARDING LOBBYING

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

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 cooperativeagreement.

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: 6/25/18

TITLE: County Manager

ORGANIZATION: County of Sullivan

NAME: (Please Print) Joshua Potosek

SIGNATURE: [signature]

EXHIBIT D
MEDICARE APPENDIX

This appendix (the "Medicare Appendix" or "this Appendix") sets forth additional terms and conditions applicable to Covered Services provided to Covered Persons enrolled in Medicare Covered Plans, established or to be established pursuant to Payor's Medicare Contract ("Medicare Contract") with CMS. To the extent any term or provision of this Appendix is inconsistent with the rest of the Agreement, this Appendix shall control as to Medicare Members. Capitalized terms used but not defined herein shall have the same meaning as in the Agreement, unless the context otherwise specifically requires.

1. **Obligations of Ancillary Provider**. Ancillary Provider agrees to provide those Covered Services which Ancillary Provider is licensed to provide, which Ancillary Provider routinely provides and for which Ancillary Provider has been credentialed by Payor to Medicare Members in accordance with the terms of the applicable Medicare Covered Plan, the Agreement, all Payor policies, procedures and manuals applicable to the Medicare Covered Plans, the Medicare Contract (which is herein incorporated by reference and made a part hereof), and all applicable Medicare laws, rules, regulations and CMS instructions. In providing Covered Services to Medicare Members, Ancillary Provider also agrees to comply with and be bound by the following:

   A. **Access to Records and Facilities**.

      (1) Books and Records. Ancillary Provider agrees that HHS, the Comptroller General of the US or their designees may audit, evaluate and inspect any books, contracts, medical records, patient care documentation and other records of Ancillary Provider and any related entity, permitted contractor, subcontractor or transferee that pertain to any aspect of services performed, reconciliation of benefit liabilities and determination of amounts payable hereunder or under the Medicare Contract, or as the Secretary of HHS may deem necessary to enforce the Medicare Contract or thisAppendix.

      (2) Facilities/Other Information. Ancillary Provider agrees to make available, for the purposes specified in Title 42, Code of Federal Regulations, §422.504(d), its premises, physical facilities and equipment, and records relating to Medicare Members, and any additional relevant information that CMS may request.

      (3) Audit Period. HHS', the Comptroller General's or their designees' right to inspect, evaluate and audit the facilities, records and information under this Paragraph A extends through ten (10) years from the final date of the Medicare Contract period or completion of audit, whichever is later,unless:

         (a) CMS determines there is a special need to retain a particular record or group of records for a longer period and notifies Payor or Ancillary Provider (or Payor notifies Ancillary Provider) at least thirty (30) calendar days before the normal disposition date;

(b) There has been a termination, dispute, or fraud or similar fault by Payor or Ancillary Provider, in which case the retention may be extended to 10 years from the date of any resulting final resolution of the termination, dispute, or fraud or similar fault; or

(c) CMS determines that there is a reasonable possibility of fraud, in which case it may inspect, evaluate and audit Ancillary Provider at any time.

(4) Confidentiality and Accuracy of Member Records. For any medical records or other health and enrollment information Ancillary Provider maintains with respect to Medicare Members, Ancillary Provider must:

(a) Safeguard the privacy of any information that identifies a particular Medicare Member. Information from, or copies of, records may be released only to authorized individuals, and Ancillary Provider must ensure that unauthorized individuals cannot gain access to or alter patient records. Original medical records must be released only in accordance with Federal or State laws, court orders, or subpoenas;

(b) Maintain the records and information in an accurate and timely manner;

(c) Ensure timely access by Medicare Members to the records and information that pertain to them; and

(d) Abide by all Federal and State laws regarding confidentiality and disclosure for mental health records, medical records, other health information and Medicare Member information.

B. **Access to Covered Services and Coverage**.

(1) Non-Discrimination. Ancillary Provider may not deny, limit, or condition the furnishing of Covered Services to Medicare Members on the basis of any factor that is related to health status, including, but not limited to the following:

(a) Medical condition, including mental as well as physical illness;
(b) Claims experience;
(c) Receipt of health care;
(d) Medical history;
(e) Genetic information;
(f) Evidence of insurability, including conditions arising out of acts of domestic violence; or
(g) Disability.

(2) Access Standards. Ancillary Provider agrees to provide and continuously

monitor timely access to care in accordance with Payor and CMS standards, and to take corrective action on request to ensure compliance with these standards. Ancillary Provider agrees to comply with Payor's policies and procedures (e.g. coverage rules, practice guidelines, payment policies and utilization management) that allow for individual medical necessity determinations, and to consider input from the Medicare Member as to the proposed treatment plan in accordance with Payor standards.

(3) Ancillary Provider shall:

(i) comply with New York and Federal law, whether statutory or recognized by the courts of competent jurisdiction, on advance directives;

(ii) maintain in treatment records all relevant information concerning advance directives regarding Medicare Members;

(iii) cooperate with Crystal Run's educational efforts regarding advance directives; and

(iv) not condition treatment or otherwise discriminate against a Medicare Member on the basis of whether the Medicare Member has executed an advance directive.

C. Medicare Member Protections.

(1) Continuity and Quality of Care. Ancillary Provider shall cooperate with and abide by Payor's procedures to ensure that Payor and other network providers have the information required for effective and continuous patient care and quality review, including: maintaining a health record in accordance with standards established by Payor; and ensuring that there is an appropriate and confidential exchange of information regarding the Medicare Member with other network providers who provide care to the Medicare Member. Ancillary Provider agrees to provide Covered Services to Medicare Members in a manner consistent with professionally recognized standards of health care.

(2) Confidentiality. Ancillary Provider agrees to comply with the confidentiality and enrollee record accuracy requirements set forth in Paragraph A.4 above.

(3) Hold Harmless. Ancillary Provider agrees that Medicare Members shall be held harmless from payment of any fee which is the legal obligation of Payor. Ancillary Provider shall look solely to Payor for compensation for Covered Services rendered pursuant to this Exhibit, except for permitted deductibles, coinsurance or copayments pursuant to the applicable Medicare Covered Plan. Ancillary Provider agrees that in no event, including but not limited to nonpayment by Payor, Payor's insolvency or breach of this Agreement, or

Ancillary Provider's failure to submit a bill to Crystal Run on a timely basis, shall Ancillary Provider seek compensation, remuneration or reimbursement from, or have any recourse against, a Medicare Member, or others acting on a Member's behalf, for Covered Services provided pursuant to this Appendix. This provision shall not prohibit Ancillary Provider from collecting permitted deductibles, coinsurance, or copayments pursuant to the terms of the applicable Medicare Covered Plan. Ancillary Provider agrees that this provision shall be construed to be for the benefit of Medicare Members, and shall survive the termination of this Agreement regardless of the reason for termination. Ancillary Provider also agrees that this provision shall supersede any contrary oral or written agreement now existing or hereafter entered into between Ancillary Provider and a Medicare Member, or any person acting on such Member's behalf, insofar as such contrary agreement relates to liability for payment for, or continuation of, Covered Services.

D. **Delegation**. Ancillary Provider agrees that to the extent Payor delegates to Ancillary Provider or permits Ancillary Provider to delegate or subcontract the performance of any obligation agreed to be performed by Payor or Ancillary Provider hereunder to a related entity, contractor, subcontractor or other party, Ancillary Provider and such other party, as a condition precedent to such delegation, subcontract or other arrangement shall comply with the following:

(1) Such delegation, subcontract or other arrangement must be in writing;

(2) All services or other activities performed by Ancillary Provider, a related entity, contractor, subcontractor or other party shall be consistent with and comply with Payor's obligations under the Medicare Contract;

(3) The written arrangement must specify the delegated activities and reporting responsibilities;

(4) The delegated activities and reporting requirements may be revoked and/or subject to other remedial action in instances where CMS or Payor determines that Ancillary Provider or such parties have not performed satisfactorily;

(5) The performance of Ancillary Provider and such parties shall be monitored by Payor on an ongoing basis;

(6) The written arrangement must specify that either:

(a) The credentials of medical professionals affiliated with the parties will be either reviewed by Payor; or

(b) The credentialing process will be reviewed and approved by Payor and Payor shall audit the credentialing process on an ongoing basis; and

(7) All contracts or written arrangements must specify that the related entity,

contractor or subcontractor must comply with all applicable Medicare laws, regulations and CMS instructions.

E. **Reporting and Disclosure**. Ancillary Provider agrees to comply with all relevant Medicare reporting requirements including those set forth in Title 42, Code of Federal Regulations, §422.516. As a condition to receiving payment, Ancillary Provider shall certify as to the accuracy, completeness and truthfulness of relevant data requested by CMS.

F. **Compliance**.

(1) Compliance With Laws. Ancillary Provider agrees to comply with: Title VII of the Civil Rights Act of 1964 as implemented by regulations at Title 45, Code of Federal Regulations, Part 84; the Age Discrimination Act of 1975 as implemented by regulations at Title 45, Code of Federal Regulations, Part 91; the Americans with Disabilities Act; other laws applicable to recipients of Federal funds; and all other applicable laws and rules.

(2) Accountability. Ancillary Provider acknowledges and agrees that Payor has the right to oversee and is accountable to CMS for any functions or responsibilities described in this Appendix.

(3) Program Exclusion. Ancillary Provider represents and warrants that neither Ancillary Provider nor any employee, agent or contractor of Ancillary Provider is, or will at any time during the term hereof be, excluded from participation in Medicare.

(4) Appeals. Ancillary Provider agrees to abide by and comply with all grievance and appeal procedures applicable to Medicare Members, and shall cooperate fully, including gathering and forwarding information to Payor, as necessary to ensure compliance with such policies and procedures. This provision shall survive termination of this Appendix.

2. **Payment and Federal Funds**.

A. Payment. For all Covered Services provided by Ancillary Provider to Medicare Members in accordance with this Appendix, Ancillary Provider shall be paid in accordance with Exhibit B. Ancillary Provider acknowledges and agrees that payments to Ancillary Provider hereunder are, in whole or in part, from Federal funds, and as such, are subject to certain laws applicable to entities and individuals receiving Federal funds.

B. Claims Turnaround Time. Payor agrees to pay Ancillary Provider's clean and uncontested claims for Covered Services provided to Medicare Members in accordance with applicable law.

C. No Inducement. Ancillary Provider acknowledges and agrees that any payments made directly or indirectly to Ancillary Provider under this Exhibit are not made as

in inducement to reduce or limit the provision of medically necessary Covered Services to Medicare Members.

3. **Term and Termination.**

A. Automatic Termination. Ancillary Provider's participation in the Medicare Covered Plan shall automatically terminate upon the sooner of: (i) termination of the Agreement; (ii) termination or non-renewal of the Medicare Contract; or (iii) Ancillary Provider's or any employee's, agent's or contractor's of Ancillary Provider sanction, disqualification or exclusion from the Medicare Program.

B. Notice. In the event the Medicare Contract is terminated or non-renewed, Payor will provide Ancillary Provider with notice of termination of the Medicare Contract and the date said termination becomes effective within thirty (30) days after Payor is notified by, or notifies, CMS of the termination or non-renewal of its Medicare Contract. Termination of the Medicare Contract shall not affect any other provisions contained in the body of the Agreement, nor to any provisions contained in this Exhibit to the extent that they apply to Covered Services rendered to Medicare Members during the term of the Medicare Contract.

C. Continuation of Care. In the event Ancillary Provider's participation in the Medicare Covered Plan is terminated, or in the event of Payor's insolvency, Ancillary Provider shall:

(1) continue to treat Medicare Members until the later of the effective date of the termination or the medically appropriate discharge or transfer of the Medicare Member,

(2) cooperate in the orderly transfer of Medicare Members to appropriate providers;

(3) provide complete copies of Medicare Member's medical records, at no cost, to other providers as directed by Payor and/or the Medicare Member; and

(4) refrain from billing, or attempting to collect from Medicare Members or others acting on Medicare Member's behalf, compensation for Covered Services provided prior to the later of (i) the appropriate transfer of Medicare Members to other providers or (ii) the termination of Ancillary Provider's termination from the Medicare Covered Plan.

4834-1853-2881, v. 4

Sullivan County
NY

Adopted
May 10, 2018 10:00 AM

Resolution
223-18

LEGISLATORS MARK MCCARTHY AND ALAN SORENSEN WERE ABSENT FOR THE ENTIRE MEETING

To Authorize Reimbursable Third Party Payor Agreements, Amendments, Updates

Information

Department: Public Health Services
Category: Agreement
Sponsors:

Attachments

Printout

Body

WHEREAS, Sullivan County Public Health Services is a provider of home care related services, including but not limited to skilled nursing, physical therapy, occupational therapy, speech therapy, respiratory therapy, social work services, and home health aide services, to clients and that such services are reimbursable by third party payors; and

WHEREAS, Sullivan County Public Health Services desires to continue to enhance third party revenue generation collection; and

WHEREAS, third party payors require written agreements with service providers to allow all payments to be forwarded directly to the provider; and

WHEREAS, due to the changing requirements in the industry, third party payors may require periodic amendments to their existing agreements.

NOW, THEREFORE, BE IT RESOLVED, that the County Manager is hereby authorized to enter into provider agreements with various insurance companies/service providers for the services described above and to sign amendments to said agreements; and

BE IT FURTHER RESOLVED, that the authorization for this Resolution shall expire as of January 1, 2024, and that a new resolution must be adopted at that time; and

BE IT FURTHER RESOLVED that said agreements and amendments shall be in such form as to be approved by the County Attorney.

Meeting History

Meeting History

May 10, 2018 10:00 AM Video **County Legislature** **Regular Meeting** **Draft**

RESULT: **ADOPTED [UNANIMOUS]**
MOVER: Nadia Rajsz, Legislator
SECONDER: Terri Ward, Legislator
AYES: Scott B. Samuelson, Nadia Rajsz, Catherine Owens, Terri Ward, Luis Alvarez, Joseph Perrello, Ira M. Steingart
ABSENT: Mark McCarthy, Alan Sorensen