FIDELIS CARE STANDARD ANCILLARY SERVICES AGREEMENT 2.0

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FIDELIS CARE

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THIS ANCILLARY SERVICES AGREEMENT, made this _____ day of _____, 2020, by and between **NEW YORK QUALITY HEALTHCARE CORPORATION, NEW YORK STATE CATHOLIC HEALTH PLAN, INC.,** corporations certified as health plans pursuant to Article 44 of the New York State Public Health Law, and including its affiliates and subsidiaries (hereinafter referred to individually as, "**Plan**" or collectively as "**Plans**") and **Sullivan County Public Health Services and the County of Sullivan, through its Department of Public Health Services** (hereinafter, "**Provider**") a public health center license pursuant to Article 28 of the New York State Public Health law..

NOW, THEREFORE, in consideration of the mutual covenants and promises set forth herein, the parties hereto agree as follows:

AGREEMENT

1. **Definitions**. As used in this Agreement, the following terms shall have the indicated meanings:

1.1. "**Ancillary Services**" shall mean those Health Care Services other than Primary Care Services, Specialist Services and Hospital Services, including laboratory, pathology, radiology, diagnostic testing, pharmacy, home health care and all therapies, disposable and durable medical equipment, optical and auditory equipment, and transportation (ambulette and ambulance), as more fully set forth in **Schedule 1.1** of this Agreement.

1.2. "**Clean Claim**" shall mean a claim for Health Care Services, submitted electronically in a format designated by Plan(s) that contains all the data elements required by Plan to process and adjudicate the claim.

1.3. "**Emergency**" shall mean a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent lay person, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of the person or others in serious jeopardy; (ii) serious impairment of such person's bodily functions; (iii) serious dysfunction of any bodily organ or part of such person; or (iv) serious disfigurement of such person.

1.4. "**Enrollee**" shall mean an individual who is entitled to receive those Health Care Services arranged for by Plan(s): (i) under a Program identified under **Schedule 1.14** as specified in the applicable Program Contract, and (ii) where applicable, pursuant to a Member Agreement.

1.5. "**Health Care Services**" shall mean those Medically Necessary hospital, medical and other health care services covered under and all services otherwise authorized under the terms of the applicable Program Contract and, where applicable, the Member Agreement, to which an Enrollee is entitled pursuant to such Program Contract and/or Member Agreement, including all attachments, exhibits, schedules and appendices thereto. In no event shall the meaning of "Health Care Services" include those benefits covered under the applicable Program but not provided or arranged for by Plan(s) pursuant to the applicable Program Contract, including without limitation, family Planning services.

1.6. "**Hospital Services**" shall mean those Health Care Services that are routinely provided by a health-care facility on an in-patient, emergency, or ambulatory surgery basis, except that Hospital Services do not include Ancillary Services.

1.7. "**Medical Director**" shall refer to Plans' Chief Medical Officer as defined in Section 3.2 of this Agreement or his or her designee.

1.8. "**Medically Necessary**" or "**Medical Necessity**" shall mean those health care services that are determined by a physician to be essential to the health of an Enrollee in accordance with professional standards accepted in the medical community. The Medical Director shall make the final determination of whether a service is Medically Necessary, subject to Plan(s)'s grievance procedures and compliance with the applicable Program Contract.

1.9. "**Member Agreement**" shall mean the executed agreement between Plan(s) and the applicable Enrollee for the provision of Health Care Services.

1.10. "**Personnel**" shall mean physicians, nurses, other appropriate health care professionals and technical personnel who are employees on Provider's staff or are independent contractors of Provider.

1.11. "**Physician**" shall mean an individual who is duly licensed and currently registered by the State of New York to practice medicine, who is credentialed by Plan(s) and who shall provide Health Care Services to Enrollees.

1.12. "**Plan(s) Provider**" shall mean a licensed or certified health care professional, professional organization, institution or independent practice association that contracts with Plan(s) to provide or arrange for the provision of Health Care Services to Enrollees.

1.13. "**Primary Care Physician**" shall mean a Physician who has agreed to supervise, coordinate and serve as case manager with respect to all Health Care Services provided to Enrollees who have selected or been assigned to such Primary Care Physician. Primary Care Physician shall mean an internist, family practitioner or pediatrician or other Physician who has been designated by Plan(s) as a Primary Care Physician. Primary Care Physicians may be assisted in carrying out their responsibilities under this Agreement by nurse practitioners or others who are not Physicians to the extent authorized by law.

1.14. "**Program**" shall mean those Federal, state or other programs, identified in **Schedule 1.14** of this Agreement, under which Plan(s) arranges to provide prepaid health services to Enrollees on a contractual basis. **Schedule 1.14** may be amended by Plan(s) from time to time to add or delete Programs.

1.15. "**Program Contract**" shall mean the contracts identified in **Schedule 1.14** of this Agreement, entered into by and between Plan(s) and a federal, state, or local agency or other third party, under which Plan(s) provides or arranges to provide prepaid health services to Enrollees. **Schedule 1.14** may be amended by Plan(s) from time to time to add or delete Programs. Program Contract shall include the contract itself and all attachments, exhibits, schedules or appendices to such contract, as they may be amended from time to time, and the Program Contracts are hereby incorporated by reference in their entirety as if specifically and fully set forth herein.

1.16. "**Provider Manual**" shall mean the description, entitled "Provider Manual" and prepared by Plan(s), of certain requirements, policies and procedures of Plan(s) generally applicable to all Plan(s) Providers.

2. Responsibilities of Provider

2.1. Provision of Ancillary Services.

2.1.1. General. Provider shall provide Ancillary Services to Enrollees. All Ancillary Services shall be provided in accordance with (i) this Agreement, (ii) the applicable Program Contract, and (iii) Plan(s) rules, policies and procedures, including without limitation, those set forth in the Provider Manual (collectively, for the purposes of this Section 2.1.1, the "Policies and Procedures"). Provider shall comply fully with and abide by all Policies and Procedures established by Plan(s), including without limitation, those pertaining to quality improvement, quality management, utilization management (including without limitation, precertification or preauthorization procedures, referral process or protocol, and reporting of clinical Encounter Data), Enrollee grievances and credentialing. Plan(s) shall provide any such Policy and Procedure to Provider prior to the implementation date for such Policy and Procedure. Provider agrees to be bound by and comply with all terms and conditions of the Program Contract applicable to the provision of Ancillary Services by Provider as if Provider was a party to such Program Contract. Program Contracts will be made available by Plan(s) to Provider upon request. If there are any inconsistencies between the terms of this Agreement and any Program Contract, the Program Contract shall control over this Agreement.

2.1.1a Pursuant to 21st Century Cures Action Section 5005, Provider must enroll in New York State Medicaid Program by completing and filing the designated enrollment application and providing the required information necessary for enrollment. In the event a provider is terminated from, not accepted to, or fails to submit a designated enrollment application to the New York State Medicaid Program, provider shall be terminated from participating as a provider in the Plan(s)'s network that services individuals eligible to receive Medicaid or Child Health Insurance Program.

2.1.1.1. Provider agrees to accept Enrollee rosters and other such information or communications from Plan(s) electronically through a medium designated by the Plan(s).

2.1.2. Personnel to be Bound. Provider shall ensure that all Personnel shall be bound, in writing, by any terms of this Agreement which are applicable to them, including where an obligation is placed upon Provider by this Agreement but such obligation may be performed or could be violated by Personnel.

2.1.3. Notice to Plan(s) of Adverse Effects on Ability to Provide Services. Provider shall notify Plan(s) or, if appropriate, cause Personnel to notify Plan(s) immediately, but in any event within forty-eight (48) hours, of the occurrence of any of the following:

2.1.3.1. any act taken to restrict, suspend or revoke any license, registration or certification held by Provider or any Personnel, or any disciplinary action initiated or taken against Provider or any Personnel by a hospital, government agency or professional society,

including without limitation, exclusion by the Medicare or Medicaid programs or, if applicable, loss of certification by such programs;

2.1.3.2. any event or situation that is required (under applicable laws or regulations) to be reported to the New York State Department of Health, the Program, or other state or federal agencies regulating Provider or Personnel;

2.1.3.3. any charge or conviction of a felony offense with respect to Provider; and

2.1.3.4. any other situation which might adversely affect Provider's ability to properly carry out its obligations under this Agreement including, if applicable to Provider, loss of accreditation by The Joint Commission ("TJC") or other such accrediting body or any enforcement action that affects Provider's operating certificates.

2.2. Standards for Provision of Services.

2.2.1. Non-Discriminatory Access and Treatment. Ancillary Services provided to Enrollees by Provider and Personnel shall be performed in the same manner, on the same basis and in accordance with the same standards offered to all of the other patients and clients of Provider, and shall be available and accessible to all Enrollees. Neither Provider nor any Personnel shall unlawfully differentiate or discriminate in the treatment of Enrollees or in the quality of the Ancillary Services delivered to Enrollees on the basis of race, color, religion, creed, gender, age, marital status, veteran status, national origin, disability, sexual orientation, source of payment or type of illness or condition. The parties to this Agreement also agree to comply with the applicable requirements of the Americans with Disabilities Act. In addition, Provider shall, and shall require Personnel to, protect Enrollee's rights as patients, including their rights to confidentiality regarding medical information.

2.2.2. Traditional Relationships Maintained. Provider remains responsible for ensuring that Ancillary Services provided to Enrollees hereunder by Provider and Personnel comply with all applicable provisions of federal, state and local laws, rules and regulations, including requirements for continuation of medical care and treatment of Enrollees after any termination or expiration of this Agreement or the Program Contract. Nothing contained herein shall be construed to place any limitations upon the responsibilities of Provider and Personnel under applicable laws with respect to the medical care and treatment of patients. However, nothing in this Section 2.2.2 shall preclude consultation between the Medical Director and Provider or Personnel regarding the manner of rendering care and services and other aspects of care and services, such as quantity and quality.

2.2.3. Qualification of Personnel. Provider shall engage a sufficient number of duly qualified Personnel so that Ancillary Services are provided in a competent and timely manner. Provider shall require all Personnel to be duly licensed, registered or certified in their field and to practice in accordance with all applicable laws and regulations and all rules, regulations and bylaws of Provider.

2.2.4. Credentialing. Provider shall determine the criteria for selection of Personnel, which shall, at a minimum, be consistent with the credentialing policies of Plan(s), as set forth in the Provider Manual, as such policies may be modified by Plan(s) from time to time. At the request of Plan(s) from time to time and with reasonable notice, Provider shall provide to

Plan(s) such written verification or other substantiation as requested by Plan(s) that Personnel satisfy Plan(s)'s and, if applicable, Provider's credentialing criteria. Provider shall provide to Plan(s) a complete report, updated at least every three (3) months, of all Personnel who are engaged in delivering Ancillary Services to Enrollees. For all Personnel, such report shall state their name, profession, license number, professional education, and DEA number if applicable, and professional liability insurance carrier and policy limits. The foregoing provisions of this Section 2.2.4 shall not require the release or other disclosure by any person of any records or other documents or information to the extent that such release or other disclosure is prohibited by or otherwise contrary to any applicable law. Nothing in this Section 2.2.4 is intended, nor shall be construed, to mean that Plan(s) has delegated to Provider Plan(s)'s responsibility or right to credential Personnel through Plans' credentialing process. Provider and Plan(s) understand and agree that all Personnel must be credentialed and approved by Plan(s) prior to rendering Ancillary Services to Enrollees.

2.3. Verification of Referrals, Approvals and Coverage. Provider shall follow, and shall require Personnel to follow, the procedures established by Plan(s) for verification of referrals and authorized admissions and other treatment of Enrollees and of individuals' respective entitlement to receive services as Enrollees as set forth in the Provider Manual.

2.4. Referrals. Provider shall make, and shall require Personnel, to make all referrals in accordance with Plans' referral procedures. In the event that there is no appropriate Plan(s) Provider for a Health Care Service, Provider or Personnel shall contact the Medical Director for coordination of provision of such Health Care Service. In an Emergency, Personnel may, within the permissible scope of their professional practice, refer the Enrollee to the nearest hospital and shall notify Plan(s) that an Emergency referral was made as soon as possible, but no later than forty-eight (48) hours thereafter.

2.5. Enrollee Complaints and Grievance Procedures. Provider agrees to cooperate, and shall require Personnel to cooperate, with Plan(s) in resolving any Enrollee complaints or grievances that may arise relating to the provision of Ancillary Services to Enrollees. Plan(s) and Provider agree that any complaints received by Plan(s) with respect to the provision of Ancillary Services shall be handled in accordance with Plan(s)'s complaint and grievance procedures as set forth in the Provider Manual.

2.6. Enrollees.

2.6.1. Enrollee Selection. Provider understands and agrees that Enrollees shall have the right to freely select from among Plan(s) Providers, including Provider and Personnel, in order to obtain Health Care Services.

2.6.2. Acceptance of Enrollees. Provider understands and agrees that Provider will accept all Enrollees who select, or are referred to, them for Ancillary Services. In the event that Provider determines that it is unable to provide Ancillary Services to an Enrollee, Provider may make a written request to Plans' Member Services Department stating the specific reason and requesting that the applicable Enrollee be transferred to another Plan(s) Provider and, if applicable, that no additional Enrollees be referred to Provider or Personnel. Provider agrees that (i) the Enrollee's needs and preferences shall be given significant weight in Plans' consideration of Provider's transfer request, and (ii) Plans' determination of whether to transfer the Enrollee shall be final.

2.6.3. Transfer of Enrollees. Provider shall cooperate, and shall require Personnel to cooperate, in the transfer in or out of any Enrollee making a change in Plan(s) Provider, including forwarding or receiving of such Enrollee's complete medical records. The cost of all copies of an Enrollee's medical record made incident to such a transfer shall be borne by the Provider.

2.7. TJC Survey Results. If applicable to Provider, Provider shall submit the results of its TJC survey to Plan(s) within one (1) week of the receipt thereof. If Provider elects to be surveyed by an alternate organization comparable to TJC, Provider shall agree to submit the results of the survey by the alternate organization within one (1) week of the receipt thereof.

3. Responsibilities of Plan(s)

3.1. Administrative and Other Services. Plan(s) shall be ultimately responsible for all administration and management of Health Care Services, as necessary to establish and operate a prepaid health services Plan(s) for Enrollees and persons receiving Program benefits who seek to be Enrollees, including but not limited to the following:

3.1.1. Financial and Claims Payment Services. Plan(s) shall provide all financial services, which shall include, at a minimum, billing under the Program Contract, appropriate financial reporting and, where applicable, claims payment to Provider.

3.1.2. Implementation of Quality Assurance and Utilization Review. Plan(s) and Provider acknowledge that Plan(s) shall implement and have ultimate responsibility for the quality assurance and utilization review programs as set forth in the Provider Manual.

3.1.3. Provider-Related Services. Plan(s) shall be responsible for all provider relations and orientation for Personnel, including provider relations meetings, consultations and other programs.

3.1.4. Enrollee Services. Plan(s) shall provide to or arrange for the provision to Enrollees all services of Plan(s) that are not Ancillary Services, including processing of complaints and grievances and preparation and dissemination of new Enrollee packets and other written materials given to Enrollees to explain the Health Care Services provided or arranged for by Plan(s) and the procedures for receiving same.

3.2. Medical Director(s). Plan(s) shall provide the services of one (l) or more Physicians to serve as Medical Director(s) for Plan(s), as necessary for the proper administration of Plan(s) and general coordination of Plans' medical care delivery system. The responsibilities of the Medical Director(s) shall include: general coordination of Plan(s)'s medical care delivery system, appropriate professional medical staffing of Plan(s), design and review of quality assurance protocols and utilization control procedures for Plan(s), and implementation of quality assurance and utilization management programs and continuing education requirements as may be required for Plan(s) Providers.

4. Quality Assurance and Utilization Management

4.1. Participation. Provider shall participate in and comply with, and require all Personnel to participate in and comply with, the quality assurance program, implemented pursuant to Section 3.1.2 above, to promote the rendering of quality health care and quality service. Provider understands that said quality assurance program shall include a peer review program with

respect to treatment of all Enrollees. Provider shall provide to Plan(s), and shall require all Personnel to provide to Plan(s), all information identified by Plan(s) and the New York State Department of Health necessary to conduct quality assurance and utilization review or for New York State Quality Assurance Reporting Requirements and HEDIS reporting. Provider also shall participate in and comply with, and shall require all Personnel to participate in and comply with, the utilization review program, implemented pursuant to Section 3.1.2 above, to review the provision of all Ancillary Services to Enrollees in order to provide cost effective care to Enrollees. In addition, Provider shall, and shall cause Personnel to, promote Plan(s)'s preventative medicine and health education programs for Enrollees.

4.2. Provision of Information. Provider represents and warrants that the information provided to Plan(s) in connection with utilization review and quality assurance will be accurate and complete at all times, and any material changes in such information shall be disclosed to Plan(s) without delay. Provider shall, at its sole cost and expense and to the extent permitted by law, furnish and require all Personnel to furnish copies of such pertinent sections of an Enrollee's medical records as may be required to implement said program. The foregoing provisions of this Section 4 shall not require the release or other disclosure by any person of any records or other documents or information to the extent that such release or other disclosure is prohibited by or otherwise contrary to any applicable law.

5. Financial Relationship

5.1. Billing Responsibility.

5.1.1. Billing to Plan(s). For each Program Contract, Provider shall bill the applicable Plan(s) for all Ancillary Services rendered to Enrollees by Provider and Personnel pursuant to the terms of this Agreement, and shall not render or permit any Personnel to render individual bills to Enrollees unless expressly approved in advance by Plan(s) and Enrollee.

5.1.1.1. Provider agrees to submit claims for services rendered to Enrollees and to accept remittance advices and other such claims and payment related communications electronically through a medium designated by the Plan(s).

5.1.2. Non-Covered Services. In the event that an Enrollee requires or requests a service that is not covered or authorized by Plan(s), and such service is also not covered by the Program through which Enrollee is entitled to receive services, Provider or Personnel must:

5.1.2.1. inform the Enrollee that the Enrollee will be personally responsible for all fees related to the service and the estimated fee for the service. In the event that Provider or Personnel has not been given a list of Health Care Services by Plan(s) and/or Provider or Personnel is uncertain as to whether a service is covered, Provider or Personnel shall contact Plan(s) and obtain a coverage determination prior to advising an Enrollee as to coverage and liability for payment and prior to providing the service;

5.1.2.2. obtain an executed acknowledgment of financial responsibility from Enrollee or Enrollee's legal representative prior to the time such services are provided; and

5.1.2.3. obtain Plans' and Enrollee's express prior approval.

Only if these steps have been taken shall Provider be entitled to bill the Enrollee and collect for such services.

5.2. Sole Compensation.

5.2.1. Provider shall accept, as full and complete payment for Ancillary Services rendered to Enrollees, a payment in accordance with the rates, terms and conditions set forth in **Schedule 5.2.** Provider hereby understands and agrees that the rates shall be established, and may be modified by Plan(s) from time to time, in accordance with applicable laws and regulations.

5.2.2. Under no circumstances, including, but not limited to, non-payment by or insolvency of Plan(s) or breach of this Agreement, shall Provider (and Provider shall cause Provider's Personnel or anyone carrying out any of Provider's obligations under this Agreement not to) bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, have any recourse against, or make any other claim against an Enrollee or any other person (other than Plan(s)) acting on his or her behalf, for Ancillary Services rendered to an Enrollee pursuant to the applicable Program Contract or Member Agreement and this Agreement, for the period covered by the paid Enrollee premium. In addition, with respect to Enrollees covered under a Program Contract for Medicaid managed care, Provider shall not, and shall cause Provider's Personnel not to, bill the applicable County Department of Social Services or the New York State Department of Health for Health Care Services as specified in the applicable Program Contract. This provision shall not prohibit Provider or Personnel from collecting co-payments (if any) expressly permitted by Plan(s) or fees for uncovered services provided on a fee-for-service basis as set forth in Section 5.1 above. Provider and Plan(s) acknowledge and agree, and Provider shall cause Provider's Personnel to acknowledge and agree, that Enrollees under Plan(s)'s Medicaid managed care program, and Plan(s)'s Child Health Plus program, are not subject to any co-payments.

5.2.3. Provider further agrees, and shall cause Provider's Personnel to agree, that (i) this Section shall survive the termination or expiration of this Agreement regardless of the cause giving rise to said termination and shall be construed for the benefit of the Enrollee, (ii) this Section supersedes any oral or written agreement to the contrary now existing or hereinafter entered into between Provider and any Enrollee or any person acting on Enrollee's behalf, and (iii) Provider shall, at Plans' reasonable request, require any Personnel providing Ancillary Services to Enrollees to agree to the terms of this paragraph in writing.

5.3. Timing of Payment. Payment for services rendered shall be made within thirty (30) days of receipt by Plan(s) of an electronic Clean Claim. All payments will be made in accordance with the requirements of Section 3224-a of the New York State Insurance Law. Plan(s) shall only be responsible for payment to Provider of Clean Claims received within ninety (90) calendar days of service, unless such claims have been subject to recovery through coordination of benefits or unless otherwise required by law. If adjustments in the payment are required for any reason, they shall be made in due course during subsequent regular payment cycles. All payments to Provider shall be subject to coordination of benefits and other non-duplication of payments rules. Provider shall have: (i) sixty (60) calendar days from the date of any final payment determination to request a review of such payment determination pursuant to the dispute resolution process set forth in the Provider Manual, or (ii) if such payment determination was based upon criteria pursuant to Article 49 of the Public Health Law, sixty (60) calendar days in which to appeal such payment determination pursuant to the dispute resolution process set forth in the Provider Manual. Provider agrees to submit claims for services rendered to enrollees electronically through a medium designated by the Plan(s).

5.4. Fee Disputes. Provider agrees, and shall cause Provider's Personnel to agree, that any fee dispute shall be resolved according to Plans' dispute resolution process set forth in the Provider Manual and the arbitration provisions of Section 11.6 of this Agreement, which arbitration determination is binding upon Plan(s) and Provider. Provider agrees and acknowledges that, and shall cause Provider's Personnel to agree and acknowledge that, notwithstanding any payment decision made by Plan(s) or Plans' Medical Director, Provider and Personnel remain solely responsible for all professional and medical judgments made pursuant to this Agreement.

5.5. Coordination of Benefits. Provider shall, and shall cause Provider's Personnel to, cooperate with Plan(s) in the coordination of benefits between Plan(s) and third party insurers where applicable to any Enrollee. Provider shall maintain, and shall require Personnel to maintain, adequate records reflecting collection of any coordination of benefits proceeds by Provider or Personnel regarding Enrollees, and the amounts thereof. Provider shall, and shall cause Provider's Personnel to, make records regarding collections of coordination of benefits proceeds available to Plan(s) and any appropriate federal, state, county, or city regulatory agency, and shall, upon request, provide copies of said records to any appropriate federal, state, county, or city regulatory agency without charge. This paragraph shall survive the termination of this Agreement.

6. Adherence to Ethical and Religious Directives

Nothing contained in this Agreement shall require or cause Plan(s) to pay, reimburse, arrange or provide any service or participate in any activity which is not in accordance with the Ethical and Religious Directives for Catholic Healthcare Services issued by the United States Catholic Conference, available for review upon request to Provider, as interpreted by the Bishop of the Diocese in which Provider renders services to Enrollees.

7. Records and Reports

7.1. Maintenance of Medical Records. Provider shall maintain, and shall require Personnel to maintain, medical records pursuant to established Plan(s) standards for the maintenance of medical records relating to the provision of Ancillary Services to Enrollees, including without limitation, in such form and containing such information as are reasonably required by Plan(s), considering the relevant requirements of federal, state and local law. As necessary, Provider shall forward, and shall require Personnel to forward, to Plan(s), in a prompt manner, any clinical information pertaining to Enrollees. Provider shall maintain, and shall require all Personnel to maintain, all medical records relating to Enrollees for the greater of six (6) years from age of majority or the length of time physicians or other providers, as the case may be, are required to maintain patient records under applicable New York law, which obligations shall survive any termination or expiration of this Agreement.

7.2. Confidentiality and Access.

7.2.1. Confidentiality. The parties agree, and Provider shall cause Personnel to agree, that all Enrollees' medical records shall be treated as confidential so as to comply with all federal and state laws and the applicable Program Contract regarding the confidentiality of medical records. Provider shall, or shall cause Personnel to, obtain consent for disclosure of medical records to Plan(s) and applicable state and federal monitoring and oversight agencies from Enrollees upon each Enrollee's initial visit, where reasonably feasible, but in any event prior to disclosure of such information if required by applicable law.

7.2.2. Access to Provider Records. Unless expressly prohibited by law regarding confidentiality or otherwise, Provider shall permit, and shall require Personnel to permit: (i) Plan(s) and/or appropriate federal, state, county and city regulatory agencies to have access to or to receive copies of to Enrollees' medical records and encounter data; and (ii) upon request, an appropriate federal, state, county or city regulatory agency to receive copies at no charge of any accounting, administrative, and medical records maintained by Provider, or by Personnel, to the extent such records pertain to Plan(s), Enrollees and/or Provider's participation in this Agreement. Provider acknowledges and agrees that Provider shall also provide, or shall cause Personnel to provide, to Plan(s) or any applicable federal, state, county or city regulatory agency, upon request, all financial data and reports and information concerning the appropriateness and quality of services provided to Enrollees, to the extent authorized by law. Additionally, where Enrollee medical records, encounter data or any financial information pertain to services provided pursuant to Medicaid, Provider shall, or shall cause Personnel to, disclose the nature and extent of services provided and shall furnish such records to the New York State Department of Health, the United States Department of Health and Human Services, the applicable County Department of Social Services, the Comptroller of the State of New York, the New York State Attorney General and the Comptroller General of the United States and their authorized representatives upon request. Provider and Personnel may not charge for the costs of any such copies or information.

7.2.3. Access to Plan(s) Records. Plan(s) shall permit Provider to have access to and, upon request, to inspect and copy at reasonable times any records maintained by Plan(s) related to the provision of Ancillary Services to Enrollees or the compensation of Provider under this Agreement.

7.2.4. Survival. The obligations set forth in this Section 7.2 shall survive any termination or expiration of this Agreement.

7.3. Financial and Operating Records and Reports. Provider shall provide such medical, financial, and administrative information to Plan(s), or its authorized representatives, as may be necessary for compliance by Plan(s) with the Program Contract and federal or state law, rules or regulations. The information referred to in the preceding sentence shall include all financial, enrollment, budget, operating, utilization and other information, as well as estimates and projections that may be necessary for reports or information required or requested by the State of New York or other governmental regulations or that may be necessary for billing or desirable for establishing rates of payment under any Program Contract. Provider shall, and shall require all Personnel to, maintain its financial records concerning Ancillary Services rendered under this Agreement for the greater of seven (7) years or the length of time required by federal or state law. The obligations set forth in this Section 7.3 shall survive any termination or expiration of this Agreement.

8. Term and Termination

8.1 Term of Agreement. This Agreement shall commence on the date first set forth above (the "Effective Date"). Subject to earlier expiration or termination as provided in Sections 8.2 and 8.3 below, this Agreement shall continue in effect for a period of one (1) year from the Effective Date and shall thereafter, subject to all required government approvals under the Program Contract and any other required government approvals, shall be renewed automatically for successive one (1) year periods. However, with

respect to New York State Catholic Health Plan(s), Inc., this Agreement shall terminate on December 31, 2020.

8.2 Non-Renewal. This Agreement may expire upon any anniversary of the Effective Date; provided that the party desiring not to renew this Agreement provides the other party with at least sixty (60) calendar days prior written notice of its intent not to renew.

8.1. Termination of Agreement. Notwithstanding the foregoing, this Agreement may be terminated as follows:

8.1.1. Termination by Mutual Consent. This Agreement may be terminated at any time by mutual written consent of the parties.

8.1.2. Termination by Plan(s).

8.1.2.1. Provider. With respect to Provider, Plan(s) may terminate this Agreement: (i) upon the material default or breach by Provider of one or more of its obligations hereunder if such default is not cured within sixty (60) calendar days after receiving notice of termination due to material breach; (ii) if any Program Contract terminates; (iii) Provider's loss of its legal status under New York law; (iv) if applicable to Provider, Provider's loss of its operating certificate under Article 28 of the New York Public Health Law, loss of its accreditation by TJC or other such accrediting body or its certification under the Medicare or Medicaid programs; (v) Plan(s)'s determination, in its sole discretion, that Provider's continued provision of Ancillary Services under this Agreement creates an imminent harm to Enrollees; or (vi) Provider's exclusion from the Medicare or Medicaid programs.

8.1.2.2. Personnel. With respect to Personnel licensed according to Title 8 of the New York State Education Law, subject to the due process rights created by Section 4406-d of the New York Public Health Law, Provider shall, at Plans' request, terminate the provision of Ancillary Services to Plan(s) Enrollees by any Personnel upon the default or breach by such Personnel of a material breach of one or more of his or her obligations pursuant to this Agreement or exclusion from the Medicare or Medicaid programs and Provider shall give such Personnel such prior written notice of such termination as Plan(s) would be required to provide if Plan(s) contracted directly with such Personnel.

8.1.3. Termination by Provider. Provider shall have the right to terminate this Agreement immediately upon notice in the event that Plan(s) ceases to be duly licensed under applicable New York law or fails to maintain any of the insurance coverages required by Section 9.1.

8.1.4. Termination for Bankruptcy. Either party shall have the right to terminate this Agreement in the event that the other party applies for or consents to the appointment of a liquidator of itself or of all or a substantial part of its assets, or if a judgment or decree shall be entered by a court of competent jurisdiction, on the application of a creditor, adjudicating said other party a bankrupt or insolvent or approving a petition seeking reorganization of said other party or of all or a substantial part of its assets and that judgment or decree continues unstayed and in effect for any period of thirty (30) calendar days.

8.1.5. Effective Date of Termination. Unless otherwise provided by statute or regulation, the effective date of termination shall be sixty (60) calendar days following receipt of notice of termination by the applicable party; provided that, (i) Plan(s) may effect such termination of Provider or require Provider to effect the termination of the provision of Ancillary Services to Enrollees by such Personnel upon less than sixty (60) calendar days prior written notice if Plan(s) demonstrates to the satisfaction of the New York State Department of Health that circumstances have arisen that justify immediate termination, and (ii) with respect to Personnel licensed according to Title 8 of the New York State Education Law, Provider shall immediately terminate any Personnel due to: (a) a final disciplinary action by a state licensing board or other governmental agency that impairs such Personnel's ability to practice; (b) a determination of fraud involving such Personnel; or (c) Plans' determination, in its sole discretion, that such Personnel's continued provision of Ancillary Services under this Agreement creates an imminent harm to Enrollees. Plan(s) shall notify the New York State Department of Health of any termination of an institutional Plan(s) Provider.

8.2. Effect of Termination or Expiration. As of the date of termination or expiration of this Agreement in accordance with this Section 8, this Agreement shall be considered of no further force or effect whatsoever, and each of the parties shall be relieved and discharged from its respective rights and obligations hereunder, except as otherwise specifically provided herein and except that:

8.2.1. The parties' rights and obligations under Sections 5.2, 5.5, 7.1, 7.2, and 7.3 above and 8.4.4, 8.4.5 and 9.2 below (regarding recourse for compensation, coordination of benefits, records, confidentiality and access, financial and operating records and reports, continuation of services and insurance, respectively) of this Agreement shall not be extinguished but shall continue in effect for the time periods stated therein;

8.2.2. Any or either party's rights to receive its respective payments for claims for Ancillary Services (under Article 5 above) and any sums that were earned, or due and owing, as the case may be, prior to termination or expiration of this Agreement shall continue in effect;

8.2.3. Provider and Personnel shall not be released from their obligation not to seek any payment from Enrollees for Ancillary Services provided prior to termination or expiration of this Agreement; and

8.2.4. Provider shall be obligated and shall cause Personnel to be obligated to (a) continue to render Ancillary Services to Enrollees in accordance with the terms of this Agreement (including compensation) for the longer of the period required by the applicable Program Contract or ninety (90) calendar days from the date Plan(s) has knowledge of Provider's disaffiliation from Plan(s), provided that at all times after termination or expiration, Plan(s) shall use all reasonable efforts to cause Enrollees (without discrimination based on health or otherwise) to be transferred to other Plan(s) Providers or other providers designated by Plan(s); and (b) cooperate fully in notification of Enrollees as to the termination or expiration and in effecting a smooth transition of Enrollees to other Plan(s) Providers or other providers designated by Plan(s) including forwarding, at Provider's expense, medical expense and copies of other patient records to Plan(s) and/or such other Plan(s) Providers or providers designated by Plan(s). Provider acknowledges that in accordance with the applicable Program Contract, Provider may be required to continue to provide Ancillary Services under this Agreement with respect to Enrollees until the

expiration or other termination of said Program Contract, subject, however, to the foregoing provisions of this Section 8.4.4; and

8.2.5. Notwithstanding Provider's obligations in Section 8.4.4 above, Provider shall, in addition, complete or cause Personnel to complete, any course of treatment to any individual Enrollee, in accordance with the terms of this Agreement (including compensation), for whom treatment was ongoing on the date of termination or expiration for a transitional period up to ninety (90) calendar days from the date the Enrollee is notified of the termination, or, if the Enrollee is a woman in her second trimester of pregnancy on the date of termination or expiration, for a transitional period that includes the provision of post-partum care directly related to the delivery. For Enrollees confined to an inpatient facility, Provider shall also complete, or cause Personnel to complete, any course of treatment in progress until a medically appropriate discharge or transfer is made, or completion of the course of treatment is made, whichever first occurs, provided that the confinement or course of treatment was commenced during the paid premium period. Provider acknowledges that it shall continue to provide or arrange for treatment during these transitional periods even when this Agreement terminates due to Plan(s)'s insolvency. Provider and Plan(s) understand and acknowledge that any decision to continue treatment with Provider shall be made by the applicable Enrollee during the applicable transitional period.

8.2.6. Upon termination or expiration of this Agreement for any reason, Provider must return to Plan(s) all proprietary information supplied by Plan(s) to Provider.

8.2.7. Provider and Plan(s) understand and acknowledge, if required by applicable law, that Plan(s) will report any termination of this Agreement to the New York State Department of Health and the United States Department of Health and Human Services as required by law or by a Program Contract.

8.3. Effect of Interruptions. In the event the provision of Ancillary Services to Enrollees is interrupted or substantially disrupted due to causes beyond the control of Provider, including but not limited to a major disaster, the complete or substantial destruction of Provider or Provider's facilities, acts of God or actions by any governmental authority, war, fire, earthquake, tornado, freight embargoes, flood, epidemic, quarantine restrictions, labor disturbances including slow-down strikes and lock-outs, or any other similar causes, Provider shall use its best efforts to arrange, in consultation with Plan(s) and through whatever alternative means as are necessary, and shall remain responsible for the provision of any such interrupted or disrupted Ancillary Services; provided, however, that nothing contained herein shall be construed to limit or reduce the obligation of Provider not to seek payments from Enrollees for Ancillary Services provided to such Enrollees.

9. Insurance and Indemnification

9.1. Plan(s) Insurance. Plan(s), at its sole cost and expense, shall maintain comprehensive general liability insurance with limits not less than $1 million per occurrence and $2 million in the aggregate and other coverages it deems appropriate with a limit not less than $10 million in the aggregate. Such insurance shall be obtained from a commercial insurance carrier admitted to do business in the State of New York or from a duly established and funded self- or

pooled- insurance program. Plan(s) shall, upon request, provide Provider with proof of insurance coverage.

9.2. Provider Insurance. Provider shall maintain (or cause to be in effect) comprehensive general liability insurance with limits not less than $1 million per occurrence and $3 million in the aggregate and professional liability insurance covering (i) itself, at its sole expense, with limits not less than $1.3 million per occurrence and $3.9 million in the aggregate; and (ii) each member of its Personnel at limits of not less than $1.3 million per occurrence and $3.9 million in the aggregate. Such insurance shall be obtained from a commercial insurance carrier admitted to do business in the State of New York or from a duly established and funded self- or pooled- insurance program. The professional liability insurance coverage for Personnel shall be on an occurrence basis or if on a "claims made" basis shall include appropriate tail coverage. Provider shall cause each insurance carrier providing such coverage to give to Plan(s) at least thirty (30) calendar days prior written notice of any material modification, reduction or termination of such coverage. If Provider or Personnel are self-insured, it shall maintain its reserves at least at the minimum levels actuarially determined to be necessary for satisfactory coverage. Provider shall, and shall cause Personnel, upon request, provide Plan(s) with proof of insurance coverage.

9.3. Indemnification. The parties agree to indemnify and hold each other, their agents and employees harmless from any and all loss, damage, injury, causes of action or liability, including court costs and reasonable legal fees, that are caused by or arise out of any act or omission by such party, its directors, officers, employees or agents in connection with this Agreement. Neither party shall have any obligations to indemnify and hold the other harmless with respect to court costs or legal fees, or with respect to any claims which arise out of or result from fraud or knowing misrepresentation by or on behalf of the other or arising from any of its representations or duties under this Agreement.

10. Use of Names

Provider agrees, and shall cause Personnel to agree, that Plan(s) may use Provider's and/or Personnel's identifying information in a roster of Plan(s) Providers for purposes of marketing Plan(s). Plan(s) agrees that Provider may use Plans' name in a listing of Plan(s)s in which Provider participates. Provider shall not, and shall cause Personnel not to, use the identifying information provided by Plan(s) in any advertising, marketing, enrollment or other promotional material without the prior written approval of Plan(s). In no event shall Provider or Personnel alter any trademark or service mark of Plan(s). Provider agrees, and shall cause Personnel to agree, to follow Plans' instructions in order to protect Plan(s)'s trademarks or service marks.

11. Miscellaneous

11.1. Notices. Any notice required or permitted to be given pursuant to the terms and provisions of this Agreement shall be in writing and shall be deemed given (i) when delivered, if delivered in person, (ii) four (4) calendar days after being mailed by certified or registered mail, postage prepaid, return receipt requested, or (iii) one (1) business day after being sent by receipted overnight courier to the parties, their successors in interest or their assignees at the addresses which

appear on the signature page hereto, or at such other addresses as the parties may designate by written notice in the manner aforesaid.

11.2. Assignability and Parties in Interest. This Agreement and the rights and obligations hereunder shall not be assigned, delegated or otherwise transferred by either party without the prior written consent of the other, which consent shall not be unreasonably withheld. Provider's consent is not required for an assignment of this Agreement in connection with the assigning party's sale, merger, consolidation, stock transfer or asset sale of Plan(s)'s business. This Agreement shall inure to the benefit of and be binding upon the parties hereto and their respective successors and permitted assigns. The parties acknowledge that any such assignment, delegation or transfer shall require the notification and prior approval of the New York State Department of Health.

11.3. Relationship of the Parties. None of the provisions of this Agreement are intended to create, and none shall be deemed or construed to create, any relationship between Plan(s) and Provider other than that of independent entities contracting with each other hereunder solely for the purpose of effecting the provisions of the Agreement. Neither the parties hereto nor any of their respective employees shall be construed under this Agreement to be the partner, joint venturer, agent, employer or representative of the other.

11.4. Waiver of Breach. No assent or waiver, express or implied, of any breach of any one or more of the covenants, conditions or provisions hereof shall be deemed or taken to be a waiver of any other covenant, condition or provision hereof or a waiver of any subsequent breach of the same covenant, condition or provision hereof.

11.5. Governing Law. This Agreement shall be governed by, and construed and enforced in accordance with, the laws of the State of New York applicable to contracts to be performed solely within the State.

11.6. Arbitration. Any disputes arising out of this Agreement shall be resolved, in the first instance, exclusively through the grievance process for Providers as set forth in the Provider Manual. Any appeals permitted by such grievance process, including claimed defects in the grievance process itself, shall be determined exclusively by binding arbitration before a single arbitrator selected and serving under the arbitration rules of the American Health Lawyers Association (AHLA) Alternative Dispute Resolution Service. Any such arbitration shall be held in the county in New York in which Provider maintains its principal place of business, unless special evidentiary circumstances (as determined by the arbitrator) require another venue. Such arbitration shall be the exclusive remedy hereunder. The decision of the arbitrator may, but need not, be entered as judgment in any appropriate jurisdiction in accordance with the provisions of the laws thereof, the parties hereby submitting (subject to lawful service of papers) to the jurisdiction of such courts. Copies of all requests for arbitration and any arbitrator's decision shall be given to the Commissioner of Health of the State of New York who shall not be bound by any such arbitrator's decision.

11.7. Severability. The provisions of this Agreement are severable, and, if any provision of this Agreement is held to be invalid, illegal or otherwise unenforceable, in whole or in part, in any jurisdiction, said provision or part thereof shall, as to that jurisdiction be ineffective to the extent of such invalidity, illegality or unenforceability, without affecting in any way the remaining

provisions hereof or rendering that or any other provision of this Agreement invalid, illegal or unenforceable in any other jurisdiction.

11.8. Modifications, Amendments and Waivers. Except as otherwise noted in this Agreement, mutual written agreement signed by the parties shall be required for the following actions, which may be taken at any time prior to the termination or expiration of this Agreement: (a) extending the time for the performance of any of the obligations or other acts of the parties hereto; (b) waiving compliance with any of the covenants contained in this Agreement; and (c) amending or supplementing any of the provisions of this Agreement. Notwithstanding the foregoing, Provider acknowledges that Plan(s) may amend this Agreement immediately upon written notice in order to implement changes required or requested by appropriate state or federal regulatory agencies. Any material waiver, modification or amendment of this Agreement shall require the prior approval of the Commissioner of the New York State Department of Health and shall be submitted to the Commissioner at least thirty (30) calendar days in advance of the anticipated date of execution.

11.9. No Third Party Beneficiaries. Except as specifically provided in Section 5.2, the parties agree that they do not intend to create any enforceable rights in any third parties under this Agreement and that there are no third party beneficiaries to this Agreement.

11.10. Entire Agreement. This Agreement and the Schedules and Exhibits hereto contain the entire Agreement between the parties hereto with respect to the transactions contemplated herein and shall supersede all previous oral and written and all contemporaneous oral negotiations, commitments and understandings relating thereto.

11.11. Compliance with Applicable Law. Plan(s) and Provider shall, and Provider shall cause Personnel to, comply with all applicable federal, state and local laws, statutes, ordinances, orders and regulations relevant to the conduct of Plans' and Provider's activities. Notwithstanding any other provision of this Agreement, the parties shall comply with the provision 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, and all amendments thereto. Plan(s) and Provider agree to comply with the rules applicable to Physician Incentive Plan(s) ("PIP") regulations contained in 42 CFR 417.479 and 42 CFR 434.70 and all requirements related to these regulations are incorporated into this Agreement as if fully set forth herein. The parties further agree that no payment will be made, directly or indirectly, pursuant to this Agreement, as an inducement to reduce or limit medically necessary services furnished to Enrollees.

11.12. Regulatory Approvals. Plan(s) shall use its best efforts to obtain any regulatory approvals that may be required of this Agreement. The "New York State Department of Health Standard Clauses for Managed Care Provider/IPA/ACO Contracts", attached to the Agreement as Appendix A, are expressly incorporated into this Agreement and are binding upon the Article 44 Plan(s)s and providers that contract with such Plans', and who are a party to this Agreement. In the event of any inconsistent or contrary language between the Standard Clauses and any other part of the Agreement, including but not limited to appendices, amendments, and exhibits, the parties agree that the provisions of the Standard Clauses shall prevail, except to the extent applicable law requires otherwise and/or to the extent a provision of the Agreement exceeds the minimum requirements of the Standard Clauses. Plan(s) and Provider acknowledge that this Agreement is subject to approval of the New York State 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 after such notice if so directed by the Department of Health. In the event any such approval is denied, or is conditioned upon certain changes hereto, Plan(s) may revise this Agreement to the extent necessary to obtain regulatory approval, subject to Provider's termination rights herein.

11.13. Prohibition On Use of Federal Funds for Lobbying. Plan(s) agrees that no Federally appropriated funds have been paid or will be paid to any person by or on behalf of Plan(s) for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of any Federal contract, the making or 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 provisions of the Medicaid Plan(s) Program Contracts prohibiting the use of Federal funds for lobbying, including requiring Provider to make all required certifications and disclosures if this Agreement exceeds $100,000, are hereby incorporated into this Agreement.

11.14. Compliance with Omnibus Reconciliation Act of 1980. To the extent that Section 952 of the Omnibus Reconciliation Act of 1980, or regulations adopted pursuant thereto, are applicable to this Agreement, Provider shall, until the expiration of four (4) years after furnishing of services under this Agreement, make available upon the request of the Secretary of Health and Human Services or the Comptroller General or its representative, this Agreement, invoices for services rendered hereunder, and the supporting documents and records as may be necessary to verify the nature and costs of this Agreement. This paragraph shall be contained in any subcontract of this Agreement between Provider and a related subcontractor. This paragraph shall survive the termination of the Agreement and the termination of any subcontract.

12. Medicare

12.1. With respect to the Programs offered to Medicare Enrollees, including the Medicare Advantage Program the following clauses shall apply:

The specific terms and conditions required by CMS to be incorporated into all Agreements between a Medicare Advantage Organization or First Tier Entity and a First Tier Entity or Downstream Entity to comply with the Medicare laws, regulations, and CMS instructions shall be referred to as the "CMS Clauses" and are attached to this Agreement as Appendix C. The CMS Clauses are hereby expressly incorporated into this Agreement and are binding upon the parties to this Agreement with respect to all services provided to Medicare enrollees. In the event of any inconsistent or contrary language between the CMS Clauses, and any other part of this Agreement, including but not limited to appendix amendments and exhibits, the provisions of the CMS Clauses shall supersede and replace any inconsistent provisions to this Agreement in order to ensure compliance with required CMS provisions, and shall continue concurrently with the term of this Agreement.

12.1.1. Plan and Provider and any contractor, subcontractor, or its transferee that provide any services under this Agreement, agree to provide the Center for Medicare and Medicaid Services (CMS), or its designees, the right to audit or evaluate, through inspection or otherwise, any and all books, contracts, medical records, patient care documentation, facilities, and equipment.

12.1.2. Plan and Provider, as well as all contractors and subcontractors of Provider, agree to maintain for a minimum of ten (10) years records relating to Medicare Enrollees, books, other records, documents and other evidence of accounting procedures and practices, physical facilities and equipment, and any additional relevant information CMS may require.

12.1.3. Plan and Provider, as well as all subcontractors of Provider, agree to abide by all Federal and State laws regarding confidentiality and disclosure of Medicare Enrollee medical records, or other Medicare Enrollee health and enrollment information.

12.1.4. Under no circumstances (including, but not limited to, non-payment by or insolvency of Plan) shall Provider, Provider's Personnel, or any subcontractor carrying out Provider's obligations under this Agreement, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, have any recourse against, or make any other claim against a Medicare Enrollee, except for deductibles and/or co-payments (if any) expressly permitted by Plan. Provider further agrees that this section shall survive termination of this Agreement regardless of the cause giving rise to said termination.

12.1.5. Provider, as well as any Provider subcontractors carrying out Providers obligations under this Agreement, shall be obligated to continue and complete any course of treatment to any individual Medicare Enrollee hospitalized on the date the CMS contract ends, through the date of discharge. Provider acknowledges that it will continue and complete any course of treatment for a hospitalized Medicare Enrollee even in the event of the Plan's insolvency, through the date of discharge.

12.1.6. Plan and Provider, as well as all subcontractors of Provider, shall comply with the applicable Medicare laws and regulations.

12.1.7. Plan shall oversee and be accountable to CMS for all required CMS contract functions and responsibilities.

12.1.8. Plan and Provider agree that this Program will not be effective until all necessary approvals, including but not limited to all State and Federal regulatory approvals, have been received.

IN WITNESS WHEREOF, Plans and Provider have executed this Agreement as of the day of the year first above written.

PROVIDER

Sullivan County Public Health Services and the County of Sullivan, through its Department of Public Health Services

Provider (Please Print)

50 Community Lane, PO Box 590
Address

Liberty, New York 12754
City, State, Zip Code

Entity Tax ID#: 146002812

Entity NPI#: 1922009919

Name: Joshua Potosek
(Please Print)

Title: County Manager

Date: 10/26/2020

Signature:

APPROVED AS TO FORM:

SULLIVAN COUNTY ATTORNEY

PLANS

NEW YORK QUALITY HEALTHCARE CORPORATION

NEW YORK STATE CATHOLIC HEALTH PLAN, INC.

95-25 Queens Boulevard
Rego Park, New York 11374

By: Alicia L. Delmont

Its: Chief Provider Operations Officer and Authorized Signatory, respectively

Date:

Signature:

SCHEDULE 1.1

ANCILLARY SERVICES

Provider will provide to Enrollees, pursuant to the terms and conditions of this Agreement and the applicable Program Contract, the following Ancillary Services:

HOME HEALTH CARE

SCHEDULE 1.14

IDENTIFICATION OF THE PROGRAMS AND PROGRAM CONTRACTS

Program:	Medicaid Managed Care
Program Contract:	The contract for the provision of Medicaid managed care services entered into by and between New York Quality Healthcare Corporation, and the New York State Department of Health, including all attachments thereto.
Program:	Health And Recovery Plan (HARP)
Program Contract:	The contract for the provision of managed care services under the New York State Health and Recovery Plan program entered into by and between New York Quality Healthcare Corporation, and the New York State Department of Health including all attachments thereto.
Program:	Essential Plan Program (EPP)
Program Contract:	The contract for the provision of managed care services under the New York State Essential Plan Program entered into by and between New York Quality Healthcare Corporation, and the New York State Department of Health/New York State of Health, including all attachments thereto.
Program:	Child Health Plus
Program Contract:	The contract for the provision of managed care services under the New York State Child Health Plus program entered into by and New York Quality Healthcare Corporation, and the New York State Department of Health including all attachments thereto.
Program:	Medicare Advantage
Program Contract:	The contract for the provision of Medicare Advantage services entered into by and between the Center for Medicare and Medicaid Services and New York State Catholic Health Plan, Inc., prior to January 1, 2021 and between the Center for Medicare and Medicaid Services and New York Healthcare Corporation after January 1, 2021 including all attachments thereto.
Program:	Managed Long Term Care
Program Contract:	The contract for the provision of managed long term care services entered into by and between the New York Quality Healthcare Corporation, and the New York State Department of Health including all attachments thereto.
Program:	Health Benefit Exchange
Program Contract:	The contract for the provision of health care services pursuant to the health insurance program created under the Patient Protection and Affordable Care Act through which individuals and small businesses can purchase qualified coverage, entered into between the New York State Department of Health and New York Quality Healthcare Corporation.

The Plan(s) may amend this schedule to include additional Programs from time to time. Provider agrees that Provider will participate in all new Programs for which Provider is qualified as determined by Plan. Provider's participation in any new Program will be effective upon thirty (30) calendar days' notice of Plan's amendment of this Schedule 1.14.

SCHEDULE 5.2

ANCILLARY SERVICES REIMBURSEMENT

Programs: Medicaid Managed Care, Health And Recovery Plan, Essential Plan Program-Aliessa, Child Health Plus, Managed Long Term Care (Fidelis Care At Home)

Home Health Services will be reimbursed according to the rates set forth below:

HCPCS	Description	Rate
T1030	Nursing Care, in the home, per diem	100% NYS Published Rate
S9131	Physical Therapy, in the home, per diem	100% NYS Published Rate
S9128	Speech Therapy, in the home, per diem	100% NYS Published Rate
S9129	Occupational Therapy, in the home, per diem	100% NYS Published Rate
S9127	Medical Social Work, in the home, per diem	$110.00
S9122	Home Health Aide, in the home, per hour	100% NYS Published Rate

Programs Medicare Advantage and Medicaid Advantage Plus

HCPCS	Description	Rate
G0299	Nursing Care, in the home, per diem	100% NYS Published Rate
G0151	Physical Therapy, in the home, per diem	100% NYS Published Rate
G0153	Speech Therapy, in the home, per diem	100% NYS Published Rate
G0152	Occupational Therapy, in the home, per diem	100% NYS Published Rate
G0155	Medical Social Work, in the home, per diem	$110.00
G0156	Home Health Aide, in the home, per 15 mins	100% NYS Published Rate
G0270	Nutrition Counseling, in the home, per diem	100% NYS Published Rate

SCHEDULE 5.2 CONTINUED

Programs: Medicaid Managed Care, Health And Recovery Plan, Managed Long Term Care (Fidelis Care At Home)

HCPCS	Description	Rate
S5170	Home Delivered Meals, per meal	$6.50
S9470	Nutrition Counseling, in the home, per diem	100% NYS Published Rate
S5160	Personal Emergency Response Service, Home Installation, one time	$45.00
S5161	Personal Emergency Response Service, Home Monitoring, monthly	$35.00
S9110	Telehealth Installation, one time	$50.00
S9110Ui	Telehealth Monitoring, monthly	$285.32

Programs: Managed Long Term Care (Fidelis Care At Home)

HCPCS	Description	Rate
G0238	Respiratory Therapy, in the home, per 15 mins	100% NYS Published Rate

Programs: Programs: Health Benefit Exchange and Essential Plan Program-QHP
Home Health Services will be reimbursed according to the rates set forth below:

HCPCS	Description	Rate
T1030	Nursing Care - RN, in the home, per diem	105% NYS Published Rate
S9131	Physical Therapy, in the home, per diem	105% NYS Published Rate
S9128	Speech Therapy, in the home, per diem	105% NYS Published Rate
S9129	Occupational Therapy, in the home, per diem	105% NYS Published Rate
S9127	Medical Social Worker, in the home, per diem	$115.50
S9470	Nutrition Counseling, in the home, per diem	105% NYS Published Rate
S9122	Home Health Aide, in the home, per hour	105% NYS Published Rate

The rates for Health Benefit Exchange and Essential Plan Program-QHP will be reimbursed less all applicable Enrollee cost sharing amounts

APPENDIX A

NEW YORK STATE DEPARTMENT OF HEALTH STANDARD CLAUSES FOR MANAGED CARE PROVIDER/IPA CONTRACTS

(Revised 4/1/2017)

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

A. Definitions for Purposes of this Appendix

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

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

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

B. General Terms and Conditions

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

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

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

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

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

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

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

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

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

9. To the extent the MCO enrolls individuals covered by the Medical Assistance Program, this Agreement incorporates the pertinent MCO obligations under the Medicaid Managed Care contract between the MCO and DOH as set forth fully herein, including:

    a. The MCO will monitor the performance of the Provider or IPA/ACO under the Agreement and will terminate the Agreement and/or impose other sanctions if the Provider's or IPA/ACO's performance does not satisfy the standards set forth in the Medicaid Managed Care contract.
    b. The Provider or IPA/ACO agrees that the work it performs under the Agreement will conform to the terms of the Medicaid managed care contract between the MCO and DOH and that it will take corrective action if the MCO identifies deficiencies or areas of needed improvement in the Provider's or IPA/ACO's performance.
    c. The Provider or IPA/ACO agrees to be bound by the confidentiality requirements set forth in the Medicaid Managed Care contract between the MCO and DOH.
    d. The MCO and the Provider or IPA/ACO agree that a woman's enrollment in the MCO's Medicaid Managed Care product is sufficient to provide services to her newborn, unless the newborn is excluded from the enrollment in Medicaid Managed Care or the MCO does not offer a Medicaid Managed Care product in the mother's county of fiscal responsibility.
    e. The MCO shall not impose obligations and duties on the Provider or IPA/ACO that are inconsistent with the Medicaid Managed Care contract or that impair any rights accorded to DOH, the local Department of Social Services, or the United States Department of Health and Human Services.
    f. The Provider or IPA/ACO agrees to provide medical records to the MCO for purposes of determining newborn eligibility for Supplemental Security

Income where the mother is a member of the MCO and for quality purposes at no cost to the MCO.

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

h. The Provider or IPA/ACO agrees to disclose to the MCO, on an ongoing basis, any managing employee who has been convicted of a misdemeanor or felony in relation to the employee's involvement in any program under Medicare, Medicaid or a Title XX services program (block grant programs).

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

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

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

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

    - The Provider or IPA/ACO is subject to the statutes, rules, regulations, and applicable Medicaid Updates of the Medicaid

program and of DOH related to the furnishing of care, services or supplies provided directly by, or under the supervision of, or ordered, referred or prescribed by the Provider. This includes 18 NYCRR 515.2 except to the extent that any reference in the regulation establishing rates, fees, and claiming instructions will refer to the rates, fees and claiming instructions set by the MCO.

- All claims submitted for payment by the Provider/IPA/ACO are for care, services or medical supplies that have been provided.
- Payment requests are submitted in accordance with applicable law.

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

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

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

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

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

13. Compliance Program Certification. The Provider agrees that if it is subject to the

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

C. Payment and Risk Arrangements

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

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

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

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

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

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

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

8. The parties agree to follow Section 3224-b(b) of the Insurance Law prohibiting an MCO from initiating overpayment recovery efforts more than 24 months after the original payment was received by a health care Provider, except where: (1) the plan makes overpayment recovery efforts that are based on a reasonable belief of fraud or other intentional misconduct or abusive billing; (2) for the Medicaid Managed Care and Family Health Plus programs, the overpayment recovery period for such

programs is six years from date payment was received by the health care Provider with written notice 30 days prior to engaging in overpayment recovery efforts. Such notice must state the patient's name, service date, payment amount, proposed adjustment, and a reasonably specific explanation of the proposed adjustment.

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

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

11. The parties agree that for a contract involving Tier 2 or 3 arrangements as described in Section VII.B of the Guidelines, the contract must:
    a. Provide for the MCO's ongoing monitoring of Provider financial capacity and/or periodic Provider financial reporting to the MCO to support the transfer of risk to the Provider; and
    b. Include a provision to address circumstance where the Provider's financial condition indicates an inability to continue accepting such risk; and
    c. Address MCO monitoring of the financial security deposit, describing the method and frequency of monitoring and recourse for correcting underfunding of the deposit to be maintained by the MCO; and
    d. Include a provision that the Provider will submit any additional documents or information related to its financial condition to the MCO, if requested by DOH.

12. The parties agree that for any contract involving an MCO and IPA/ACO, the contract must include provisions whereby:
    a. The parties expressly agree to amend or terminate the contract at the direction of DOH (applies to Tier 1, Tier 2, and Tier 3);
    b. The IPA/ACO will submit annual financial statements to the MCO, as well as any additional documents required by the MCO as necessary to assess the IPA/ACO's progress towards achieving value based payment goals as specified in the Roadmap, and the MCO will notify DOH of any substantial change in the financial condition of the IPA/ACO (applies to Tier 2 and Tier 3); and
    c. The IPA/ACO will submit any additional documents or information related to its financial condition to the MCO, if requested by DOH (applies to Tier 2 and Tier 3); and
    d. The parties agree that all Provider contracts will contain provision prohibiting Providers, in the event of a default by the IPA/ACO, from demanding payment from the MCO for any covered services rendered to the MCO's enrollees for which payment was made by the MCO to the

IPA/ACO pursuant to the risk agreement (applies to tier 2 and Tier 3).

D. Records and Access

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

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

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

4. The MCO and the Provider agree that the MCO will obtain consent directly from enrollees at the time of enrollment or at the earliest opportunity, or that the Provider will obtain consent from enrollees at the time of service is rendered or at the earliest opportunity, for disclosure of medical records to the MCO, to an IPA/ACO or to third parties. If the Agreement is between an MCO and an IPA/ACO, or between an IPA/ACO and an IPA/ACO, the IPA/ACO agrees to require the Providers with which it contracts to agree as provided above. If the Agreement is between an IPA/ACO and a Provider, the Provider agrees to obtain consent from the enrollee if

the enrollee has not previously signed consent for disclosure of medical records.

E. Termination and Transition

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

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

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

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

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

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

F. Arbitration

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

G. IPA/ACO-Specific Provisions

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

APPENDIX B
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 cooperative agreement.

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: 10/26/2020

TITLE: County Manager

ORGANIZATION: County of Sullivan, NY

NAME: (Please Print) Joshua Potosek

SIGNATURE:

Approved by OMB
0348-0046
Appendix [b]

Disclosure of Lobbying Activities

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

1. Type of Federal Action	2. Status of Federal Action:	3. Report Type:
a. contract b. grant c. cooperative agreement d. loan e. loan guarantee f. loan insurance Select one: ____	a. bid/offer/application b. initial award c. post-award Select one: ____	a. initial filing b. material change Select one: ____ **For material change only:** Year ____ Quarter ____ Date of last report ____

4. Name and Address of Reporting Entity:	5. If Reporting Entity in No. 4 is Subawardee,
Prime ____ Subawardee ____ Tier ____ *,if known:* Congressional District, *if known:* ____	Address ____ City ____ State ____ Zip code ____ Congressional District, *if known:* ____
6. Federal Department/Agency:	**7. Federal Program Name/Description:** CFDA Number, *if applicable*: ____
8. Federal Action Number, *if known*:	**9. Award Amount, *if known*:** $ ____
10. a. Name and Address of Lobbying Registrant *(if individual, last name, first name, MI)* Address ____ City ____ State ____ Zip code ____	**10. b. Individuals Performing Services** *(including address if different from No. 10a)* *(last name, first name, MI)* Address ____ City ____ State ____ Zip code ____

11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Signature ____
Print/Type Name ____
Title ____
Telephone No.: ____ Date:

Federal Use Only	Authorized for Local Reproduction Standard Form - LLL (Rev. 7-97)

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. Complete all items apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.

2. Identify the status of the covered Federal action.

3. Identify the appropriate classification of this report. If this is a followup report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.

4. Enter the full name, address, city, State and zip code of the reporting entity. Include Congressional District if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g. the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.

5. If the organization filing the report in item 4 checks "Subawardee," then enter the full name, address, city, State and zip code of the prime Federal recipient. Include Congressional District, if known.

6. Enter the name of federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.

7. Enter the Federal program name or description for the covered Federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.

8. Enter the most appropriate Federal identifying number available for the Federal action identified in item 1 (e.g. Request for Proposal (RFP) number, Invitations for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency). Included prefixes, e.g. "RFP-DE-90-001".

9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.

10. (a) Enter the full name, address, city, State and zip code of the lobbying registrant under the Lobbying Disclosure Act of 1995 engaged by the reporting entity identified in item 4 to influence the covered Federal action.
    (b) Enter the full names of the individual(s) performing services, and include full address if different from 10(a). Enter Last Name, First Name and Middle Initial (MI).

11. The certifying official shall sign and date the form, print his/her name, title and telephone number.

Appendix C

CMS Clauses

CMS requires that specific terms and conditions be incorporated into the Agreement between a Medicare Advantage Organization or First Tier Entity and a First Tier Entity or Downstream Entity to comply with the Medicare laws, regulations, and CMS instructions, including, but not limited to, the Medicare Prescription Drug, Improvement and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 ("MMA"); and

Except as provided herein, all other provisions of the Agreement between Plan and Provider not inconsistent herein shall remain in full force and effect. The provisions of this Appendix shall supersede and replace any inconsistent provisions to the Agreement, to ensure compliance with required CMS provisions, and shall continue concurrently with the term of such Agreement.

NOW, THEREFORE, the parties agree as follows:

Definitions:

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

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

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

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

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

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

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

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

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

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

Required Provisions:

First Tier or Downstream Entity ("Provider") agrees to the following:

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

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

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

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

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

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

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

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

   (i) The delegated activities and reporting responsibilities are specified as follows:

   NA

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

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

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

(v) If the MA organization delegates the selection of providers, contractors, or subcontractor, the MA organization retains the right to approve, suspend, or terminate any such arrangement.

[42 C.F.R. §§ 422.504(i)(4) and (5)]

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

Sullivan County
NY

Resolution
223-18

Adopted
May 10, 2018 10:00 AM

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 **Sponsors:**
Category: Agreement

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

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