

PROVIDER PARTICIPATION AGREEMENT

1. Please review, fill out this page, sign page 5 and return both pages by fax to CIIPA at (516) 465-8002, or send both scanned pages to ciipa@nshs.edu.

2. Please also complete the on-line Provider Data Sheet.

THIS AGREEMENT, made by and between North Shore-LIJ Network, Inc. and its related IPA, North Shore-LIJ Clinical Integration Network IPA, LLC (the entities collectively shall be referred to as the “CIIPA”), and _____ (“Provider”) a Provider licensed to practice _____ in the State of New York with an address at _____, _____ is effective as of the date of its execution by CIIPA (“Effective Date”). This Agreement sets forth the terms under which Provider agrees to participate in CIIPA.

WHEREAS, CIIPA is a multi-provider, non-exclusive network of Providers and professional clinical providers, hospitals, skilled nursing facilities and ancillary providers working together to promote high quality coordinated and efficient care to members of various managed care payors (“Payors”) and the community at large; and

WHEREAS, Provider is licensed by New York State to provide health care services and/or supplies and desires to participate in CIIPA; and

WHEREAS, CIIPA desires Provider to provide medically necessary health care services (“Covered Services”) to individuals entitled to benefits (“Covered Persons”) under various Payor benefit plans; and

WHEREAS, CIIPA and Provider desire to enter into this Provider Participation Agreement in order to define the terms of their relationship.

NOW THEREFORE in consideration of the mutual covenants, conditions and terms contained herein, the parties agree as follows:

I. PARTICIPATION IN THE NETWORK.

Upon execution of this Agreement, Provider shall become a Provider Member in CIIPA subject to the terms and conditions of this Agreement and the Bylaws/Operating Agreement of CIIPA.

A. Messenger Model

(i) **Contract Proposals.** For the period beginning upon the Effective Date of this Agreement CIIPA shall advise Provider of its receipt of contract proposals received from Payors (“Contract Proposal”). Such Contract Proposals shall describe the material terms of each Payor agreement as they relate to Provider, including but not limited to the compensation, as well as other important terms and relevant information.

(ii) **Notification.** Provider shall notify CIIPA in writing, within twenty (20) business days following receipt of a Contract Proposal, of Provider's election to either participate or not participate in the Payor agreement.

(iii) **Limitations.** Provider agrees to review the terms conditions of the Contract Proposal and the fee schedule and make an independent decision about Provider's participation in the Payor agreement. Provider acknowledges and agrees that with respect to the Contract Proposals, CIIPA is not negotiating on behalf of Provider. Provider further agrees that any information contained in a Contract Proposal is confidential and will not be shared with any of Provider's competitors and will not be utilized to facilitate any agreement among Provider's competitors. Provider and CIIPA acknowledge and agree that Provider is free to contract separately with any Payor on any terms.

(iv) **Third Party Consultant.** CIIPA may fulfill some of its obligations through a retained 3rd party agent or consultant.

B. Integrated CIIPA. The parties acknowledge that CIIPA is developing and in the process of implementing various practice standards and/or practice parameters, delineating specific protocols for treatment of specific medical conditions. These include but are not limited to clinical outcomes and performance data for each Provider, as well as establishing credentialing and utilization review and quality assessment programs. As it develops, Provider will have the opportunity to participate in CIIPA's clinically integrated network through committees and other efforts as set forth in Bylaws/Operating Agreement of CIIPA.

II. PROVIDER RESPONSIBILITIES.

A. Provision of Services. Subject to all applicable provisions, terms and conditions of the Payor agreements for which Provider has opted in, Provider shall provide medically necessary Covered Services to Covered Persons with the same care and attention that is customarily provided to all of Provider's patients. All Covered Services shall be provided in accordance with all generally accepted clinical, legal and ethical standards governing Provider. Provider shall maintain sufficient facilities and personnel to provide the Covered Services and shall ensure that Covered Services are, where necessary and appropriate, available 24 hours a day and 365 days a year, with backup capability.

B. Antitrust Guidelines. Provider agrees to comply with all Federal, State and Local Statutes and Regulations applicable to its relationship with CIIPA including those related to antitrust principles. CIIPA may from time-to-time adopt antitrust guidelines, policies and procedures for its providers.

III. TERM AND TERMINATION.

A. Initial Term. The initial term of this Agreement shall be for twelve (12) months from the Effective Date. This Agreement automatically shall renew for additional successive periods of twelve (12) months, unless earlier terminated in accordance with the provisions below or unless either party elects not to renew the Agreement by providing written notice to the other at least ninety (90) days prior to the expiration of the twelve (12) month period then in effect. The non-renewal of the Agreement pursuant to notice shall not constitute a termination of the Agreement.

B. Termination. This Agreement can be terminated by either party with or without cause upon ninety (90) days prior written notice. This Agreement may also be terminated by either party immediately upon written notice to the other party in the event of:

- (i) conduct by the non-terminating party poses imminent harm to patient care;
- (ii) a final determination that the non-terminating party has engaged in fraud;
- (iii) a final disciplinary action by a state licensing board or other governmental agency that impairs the non-terminating party's ability to provide services under this Agreement, including a decision by CMS or DOH to suspend, terminate or deny approval to participate in the Medicare or Medicaid programs;
- (iv) final determination that Provider violated antitrust guidelines or applicable law.

IV. MISCELLANEOUS.

A. Notices. All notices required under this Agreement shall be given in writing, signed by the party giving notice and delivered by hand, first-class mail overnight delivery or by electronic mail to the other party at the address set forth in the first paragraph of this Agreement. Any notice shall be deemed to have been given at the time of actual receipt or, if mailed, three (3) days from the date of mailing.

B. Compliance. To the extent required by law, the following shall apply:

(i) 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), and all amendments thereto.

(ii) The parties to this Agreement agree to comply with all applicable requirements of the Americans with Disabilities Act and any other state or federal laws governing fair employment practices, equal employment opportunity or laws prohibiting discrimination based upon race, creed, religion, sex, or national origin.

(iii) The New York State Department of Health Standard Clauses for HMO and IPA Provider Contracts attached to this Agreement as Appendix A are expressly incorporated into this Agreement and are binding upon the parties to this Agreement. In the event of any inconsistent or contrary language between the Standard Clauses and any other part

of this Agreement, including but not limited to appendices, amendments and exhibits, the parties agree that the provisions of the Standard Clauses shall prevail.

(iv) For services rendered to Covered Persons who are covered under Medicare Advantage Payor Benefit Plans, the provisions of the CMS required Medicare Advantage Addendum are expressly incorporated into this Agreement and are binding upon the parties to this Agreement. With respect to Medicare Advantage Covered Persons, the provisions of such Addendum shall prevail over any other provisions in the Agreement which may conflict or appear inconsistent with any provision in the Addendum which is attached as Appendix B.

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

D. Amendments. In the event any changes or modifications to this Agreement are required by (a) the New York State Department of Health; (b) any applicable federal, State or local laws and regulations or (c) new legislation and/or regulations or interpretation thereof (a "Mandatory Amendment"), this Agreement shall be deemed to be automatically amended upon notice to Provider of the Mandatory Amendment. CIIPA shall send notice to Provider of all other proposed amendments or modifications to this Agreement. In the event Provider does not object in writing to any such proposed amendments or modifications within ten (10) days of the date of such notice, such amendment or modification shall be deemed to have been approved by Provider. CIIPA also may, from time to time, send Provider Payor specific appendices that shall be incorporated into the terms of this Agreement to the extent that the Provider provides Covered Services to such Payor's Covered Persons.

E. Applicable Law. This Agreement will be governed by and construed in accordance with the laws of the State of New York.

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IN WITNESS WHEREOF, the parties hereto agree to the terms of the Provider Participation Agreement and attachments and both parties understand that CIIPA is not negotiating the terms of any payor agreement on behalf of any CIIPA member. The parties agree to the terms herein and that the signatory below has authority to execute this Agreement on its behalf.

CIIPA

PROVIDER

By: _____

By: _____

Print Name: _____

Print Name: _____

Title: _____

Date: _____

Date: _____

ATTACHMENTS

- Appendix A – NYS DOH Standard Clauses
- Appendix B -- Medicare Advantage Addendum

APPENDIX A

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

(Revised 1/1/07)

Notwithstanding any other provision of this agreement, contract, or amendment (hereinafter “the Agreement” or “this Agreement”) the parties 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, or between an IPA and an IPA, such clauses must be included in IPA contracts with providers, and providers must agree to such clauses.

I. 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, or which do provide or offer, a comprehensive health services plan.

“Independent Practice Association” or “IPA” shall mean an entity formed for the limited purpose of arranging by contract for the delivery or provision of health services by individuals, entities and facilities licensed or certified to practice medicine and other health professions, and, as appropriate, ancillary medical services and equipment, by which arrangements such health care providers and suppliers will provide their services 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 Providers, dentists, nurses, pharmacists and other health care professionals, pharmacies, hospitals and other entities engaged in the delivery of health care services which are licensed and/or certified as required by applicable federal and state law.

II. GENERAL TERMS AND CONDITIONS

- A. This Agreement is subject to the 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 if so directed by the Department of Health, 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.

- B. Any material amendment to this Agreement is subject to the prior approval of the Department of Health, and any such amendment shall be submitted for approval at least 30 days, or ninety (90) days if the amendment adds or materially changes a risk sharing arrangement that is subject to Department of Health review, in advance of anticipated execution. 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 or New York City, as may be required by the Medicaid managed care contract between the MCO and DOH (or New York City) and/or the Family Health Plus contract between the MCO and DOH.
- C. Assignment of an agreement between an MCO and (1) an IPA, (2) institutional network provider, or (3) 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 and (1) an institutional provider or (2) 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.
- D. The provider agrees, or if the Agreement is between the MCO and an IPA or between an IPA and an IPA, the IPA agrees and shall require the IPA'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, or DOH or SID guidelines or policies and (b) has provided to the provider at least thirty (30) days in advance of implementation, including but not limited to:
- quality improvement/management;
 - utilization management, including but not limited to pre-certification procedures, referral process or protocols, and reporting of clinical encounter data;
 - member grievances; and
 - provider credentialing.
- E. The provider or, if the Agreement is between the MCO and an IPA, or between an IPA and an IPA, the IPA 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.
- F. If the provider is a primary care Provider, the provider agrees to provide for 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.

- G. The MCO or IPA which 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's own acts or omissions, by indemnification or otherwise, to a provider.
- H. 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) and Chapter 551 of the Laws of 2006, and all amendments thereto.
- I. To the extent the MCO enrolls individuals covered by the Medical Assistance and/or Family Health Plus programs, this Agreement incorporates the pertinent MCO obligations under the Medicaid managed care contract between the MCO and DOH (or New York City) and/or the Family Health Plus contract between the MCO and DOH as if set forth fully herein, including:
 - a. The MCO will monitor the performance of the Provider or IPA under the Agreement, and will terminate the Agreement and/or impose other sanctions, if the Provider's or IPA's performance does not satisfy standards set forth in the Medicaid managed care and/or Family Health Plus contracts;
 - b. The Provider or IPA 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 (or between the MCO and New York City) and/or the Family Health Plus 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's performance; and
 - c. The Provider or IPA agrees to be bound by the confidentiality requirements set forth in the Medicaid managed care contract between the MCO and DOH (or between the MCO and New York City) and/or the Family Health Plus contract between the MCO and DOH.
 - d. The MCO and the Provider or IPA agree that a woman's enrollment in the MCO's Medicaid managed care or Family Health Plus product is sufficient to provide services to her newborn, unless the newborn is excluded from 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 that are inconsistent with the Medicaid managed care and/or Family Health Plus contracts, or that impair any rights accorded to DOH, the local Department of Social Services, or the United States Department of Health and Human Services.
- J. The parties to this Agreement agree to comply with all applicable requirements of the Federal Americans with Disabilities Act.

- K. The provider agrees, or if the Agreement is between the MCO and an IPA or between an IPA and an IPA, the IPA agrees and shall require the IPA's providers to agree, to comply with the HIV confidentiality requirements of Article 27-F of the Public Health Law.

III. PAYMENT; RISK ARRANGEMENTS

- A. **Enrollee Non-liability.** Provider agrees that in no event, including, but not limited to, nonpayment by the MCO or IPA, insolvency of the MCO or IPA, 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) acting on his/her/their behalf, for services provided pursuant to the subscriber contract or Medicaid Managed Care contract or Family Health Plus 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, he/she/it will not bill the New York State Department of Health 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 the New York State Department of Health. In the case of Family Health Plus, provider agrees that, during the time an enrollee is enrolled in the MCO, he/she/it will not bill the New York State Department of Health for Covered Services within the Family Health Plus Benefit Package, as set forth in the Agreement between the MCO and the New York State Department of Health. 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 co-payments, 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 therefor 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.
- B. **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 or Family 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.

- C. The parties agree to comply with and incorporate the requirements of Provider 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, 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 Provider or Provider group as an inducement to reduce or limit medically necessary services furnished to an enrollee.

IV. RECORDS; ACCESS

- A. 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 if applicable), for purposes including preauthorization, concurrent review, quality assurance, provider claims processing and payment. The provider will also make enrollee 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 if applicable) expressly acknowledges that he/she/it 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.
- B. When such records pertain to Medicaid or Family Health Plus 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 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.
- C. The parties agree that medical records shall be retained for a period of six (6) years after the date of service, and in the case of a minor, for three (3) years after majority or six (6) 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.
- D. 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 service is rendered or at the earliest opportunity, for disclosure of medical records to the MCO, to an IPA or to third parties. If the Agreement is between an MCO and an IPA, or between an IPA and an IPA, the IPA agrees to require the providers with which it contracts to agree as provided above. If the Agreement is between an IPA and a provider, the provider agrees to obtain

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

V. TERMINATION AND TRANSITION

- A. Termination or non-renewal of an agreement between an MCO and an IPA, 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 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 DOH's satisfaction 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.
- B. 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.
- C. If this Agreement is between an MCO and an IPA, and the Agreement does not provide for automatic assignment of the IPA's provider contracts to the MCO upon termination of the MCO/IPA contract, in the event either party gives notice of termination of the Agreement, the parties agree, and the IPA's providers agree, that the IPA 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 first occurs. This provision shall survive termination of this Agreement regardless of the reason for the termination.
- D. Continuation of Treatment. The provider agrees that in the event of MCO or IPA 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, Medicaid Managed Care contract, or Family Health Plus 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 and the IPA's contracted providers if this Agreement is between the MCO and an IPA.** This provision shall survive termination of this Agreement.
- E. Notwithstanding any other provision herein, to the extent that the provider is providing health care services to enrollees under the Medicaid Program and/or Family Health Plus,

the MCO or IPA retains the option to immediately terminate the Agreement when the provider has been terminated or suspended from the Medicaid Program.

- F. In the event of termination of this Agreement, the provider agrees, and, where applicable, the IPA agrees to require all participating providers of its network to assist in the orderly transfer of enrollees to another provider.

VI. ARBITRATION

- A. 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.

VII. IPA-SPECIFIC PROVISIONS

- A. Any reference to IPA quality assurance (QA) activities within this Agreement is limited to the IPA's analysis of utilization patterns and quality of care on its own behalf and as a service to its contract providers.

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APPENDIX B

MEDICARE ADVANTAGE ADDENDUM

This exhibit may be updated and amended at any time by CIIPA or Payor in order to comply with any local, state or federal governmental laws, rules or regulations. Participating Provider will be notified regarding these changes as soon as practicable after changes have been announced.

1. **Confidentiality of Records.** For any medical records or other information Participating Provider maintains with respect to Members, Participating Providers must establish procedures to: (a) safeguard the privacy of any information that identifies a Member; (b) release information from, or copies of, records only to authorized individuals; (c) ensure that unauthorized individuals cannot gain access to or alter Member records; (d) release original medical records only in accordance with Federal and State laws, court orders, or subpoenas; (e) maintain the records and information in an accurate and timely manner; (f) ensure timely access by Members to the records and information that pertain to them; and (g) abide by all state and federal laws regarding confidentiality and disclosure for mental health records, medical records, other health information and Member information. [42 C.F.R. § 422.118.]
2. **Prompt Payment.** Payor agrees to comply with the prompt payment provisions set forth in this Agreement. [42 C.F.R. § 422.520(b).]
3. **Hold Harmless of Members.** Participating Providers shall accept as payment in full for Covered Services provided to Members the compensation specified in this Agreement. Participating Providers agree that in no event, including, but not limited to nonpayment by Payor, Payor's insolvency, or breach of this Agreement shall Participating Provider bill, charge, collect a deposit from, or seek compensation, remuneration, or reimbursement from, or have any recourse against Members or persons other than Payor acting on Member's behalf for services provided under this Agreement. This provision shall not prohibit Participating Providers from collecting from Members any applicable co-payments or fees for non-Covered Services delivered to a Member. With respect to Covered Services furnished prior to the termination of this Agreement, this section shall survive the termination of this Agreement (regardless of the reason for termination, including insolvency of Payor), shall be construed to be for the benefit of Members, and supersedes any oral or written contrary agreement now existing or later entered into during the term of this Agreement between Participating Provider and a Member or persons acting on a Member's behalf. Participating Providers acknowledge that in the event of Payor's insolvency or other cessation of operations, benefits to Members will continue through the period for which payment from CMS to Payor has been paid, and benefits of Members who are inpatients in a hospital on the date of insolvency or other cessation of operations will continue until their discharge. No changes in the insolvency protection or continuation of benefits provisions under this Section shall be made without prior written approval of CMS, if applicable. [42 C.F.R. § 422.504(g).]
4. **Access to and Maintenance of Records.** Participating Providers hereby agree to the following: the Department of Health and Human Services ("DHHS"), the Comptroller General, or their designee may evaluate, through inspection or other means: (a) the quality, appropriateness, and timeliness of services furnished to Members; and (b) the facility where services are provided. Participating Providers further agree that DHHS, the Comptroller General, or their designees may audit, evaluate, or inspect any books, contracts, medical records, patient care documentation, and other records of Participating Providers (or its assignee) that pertain to any aspect of services performed,

reconciliation of benefit liabilities, and determination of amounts payable under CMS Contract, or as the Secretary of the DHHS may deem necessary to enforce the CMS Contract. Participating Providers agree to make available, for the purposes specified in this Section, their premises, physical facilities and equipment, records relating to Members, and any additional relevant information that CMS may require. Participating Providers further agree that DHHS, the Comptroller General, or their designee's right to inspect, evaluate, and audit extends through ten (10) years from the final date of the contract period of CMS Contract or completion of any audit, whichever is later. [42 C.F.R. § 422.504(i).] Participating Providers agree to maintain records to the extent necessary to comply with the foregoing.

5. **Compliance with Law.** The parties agree to comply with Medicare laws, regulations, and CMS instructions [42 C.F.R. § 422.504(i)(4)(v)], and agree to audits and inspection by CMS and/or its designees and to cooperate, assist, and provide information as requested, and maintain records a minimum of 10 years. [Medicare Managed Care Manual, Chapter 11, Section 100.4.]
6. **Accountability.** Payor shall oversee the provision of services hereunder and be accountable under the CMS Contract for services provided to Medicare Advantage Members by Participating Providers. [42 C.F.R. § 422.504(4)(iii).]
7. **Compliance with Payor Policies and Procedures.** Participating Provider, represents and warrants that, in performing under this Agreement, it shall comply with all applicable governmental laws and regulations and all policies and procedures of Payor, including without limitation written standards for the following: (a) timeliness of access to care and member services; (b) policies and procedures that allow for individual medical necessity determinations (e.g., coverage rules, practice guidelines, payment policies); and (c) provider consideration of Member input into the provider's proposed treatment plan. [42 C.F.R. § 422.112; 422.504(i)(4)(v); Managed Care Manual, Chapter 11, Section 100.4.]
8. **Discrimination Prohibited.** Participating Providers shall not deny, limit, or condition the furnishing of benefits to a Member on the basis of any factor that is related to health status, including, but not limited to the following: (a) medical condition, including mental as well as physical illness; (b) claims experience; (c) receipt of health care; (d) medical history; (e) genetic information; (f) evidence of insurability, including conditions arising out of acts of domestic violence; or (g) disability. [42 C.F.R. § 422.110(a).]
9. **Emergency Services.** Payor shall pay for Covered Services that are emergency services rendered to a Member to treat an emergency medical condition or for which Payor instructed the Member to seek treatment within or outside the licensed service area or Payor's provider network. The Provider treating the Member shall decide when the Member is stabilized for transfer or discharge and such decision shall be binding on Payor. [42 C.F.R. § 422.100(b).]

10. **Urgently Needed Services.** Payor shall pay for all Covered Services constituting Urgently Needed Services rendered to a Member. [42 C.F.R. § 422.100(b).]
11. **Renal Dialysis Services.** Payor shall pay for all Covered Services constituting renal dialysis services provided to a Member while the Member was temporarily outside the licensed service area. [42 C.F.R. § 422.100(b)(iv).]
12. **Screening Mammography, Influenza Vaccine, and Pneumococcal Vaccine.** Members may directly access (through self-referral) Covered Services constituting screening mammography and influenza vaccine. [42 C.F.R. § 422.100(g)(1).] Participating Providers may not bill or collect from Members co-payments or any other type of cost sharing for influenza vaccine and pneumococcal vaccine. [42 C.F.R. § 422.100(g)(2).]
13. **Direct Access to Women’s Health Specialist.** Payor acknowledges and agrees that female Members are allowed to directly access a women’s health specialist who is a Participating Provider for women’s routine and preventive health care services provided as basic benefits. Payor further agrees that it shall not deny payment for a Covered Medical Service on the basis that a female Member did not obtain a referral for such services. [42 CFR. § 422.112(a)(3).]
14. **Access to Benefits.** Participating Provider will make Covered Services available and accessible to Members twenty-four hours per day, seven days per week, when Medically Necessary, and with reasonable promptness and in a manner which assures continuity in the provision of Covered Services. [42 C.F.R. 422.112(a)(7)].
15. **Provision of Services.** Participating Providers shall provide Covered Services in a manner consistent with professionally recognized standards of health care. Participating Providers shall provide Covered Services in a culturally competent manner to all Members by making a particular effort to ensure that those with limited English proficiency or reading skills, diverse cultural and ethnic backgrounds, and physical or mental disabilities receive the health care to which they are entitled. [42 C.F.R. § 422.112(a)(8).]
16. **Exchange of Information.** Participating Providers shall maintain each Member medical record in accordance with standards established by Payor and shall cooperate with Payor to ensure that there is appropriate and confidential exchange of information. [42 C.F.R. § 422.112(b).]
17. **Advance Directives.** Participating Providers shall: (a) document in a prominent part of each Member’s medical record whether or not the Member has executed an advance directive; (b) not condition the provision of care or otherwise discriminate against a Member based on whether or not the individual has executed an advance directive; (c) comply with Payor’s policies and procedures regarding advance directives contained in the Provider Manual; and (d) comply with requirements of state and federal law

regarding advance directives, including without limitation the rules and regulations under the Medicare Advantage Program. [42 C.F.R. § 422.128.]

18. **Reporting Requirements.** Participating Providers agree to provide all documents and information necessary for Payor to comply with Payor's requirements for submitting information required by the contract between Payor and CMS and pursuant to 42 C.F.R. § 422.503 (the "CMS Contract"), as determined in the sole discretion of Payor. Participating Providers further agree, as a condition to receiving payment under this Agreement, to provide certification to the best of their knowledge, information, and belief, the accuracy, completeness, and truthfulness of the encounter and/or claims data submitted to Payor under this Agreement and in accordance with the provisions of 42 C.F.R. § 422.504(1), as may be amended from time to time. [42 C.F.R. § 422.504(a)(8); 42 C.F.R. § 422.504(1)(2) & (3).]
19. **Excluded Providers.** Payor is prohibited from employing or contracting with an individual who is excluded from participation in the Medicare program (or with an entity that employs or contracts with such an individual) for the provision of any of the following: (a) health care; (b) utilization review; (c) medical social work; or (d) administrative services. Participating Provider agrees to immediately notify Payor in the event Participating Provider is excluded from participation in the Medicare program or any administrative or regulatory proceedings is initiated that could lead to the exclusion of Participating Provider from the Medicare program. [42 C.F.R. § 422.752(a)(8).] In such event, Payor may immediately terminate this Agreement with regard to such employee or contractor.
20. **Medicare as Secondary Payor.** Participating Providers shall not be entitled to payment by Payor for the provision of Covered Services to the extent that the Medicare program is not the primary payor, as determined in accordance with the relevant provisions of section 1862(b) of the Social Security Act and 42 C.F.R. Part 411, except as set forth in this Section. Participating Providers agree to assist Payor in identifying payors that are primary to the Medicare program, determining the amounts payable by those payors and coordinating Covered Services with the benefits of the primary payer in accordance with the Payor Provider Manual relating to coordination of benefits. Provider is authorized to charge other individuals or entities for Covered Services provided to a Member for which Medicare is not the primary payor, as follows: if such Covered Services are also covered under (a) State or federal workers' compensation, any no-fault insurance or any liability insurance policy or plan, including a self-insured plan, Provider may charge: (i) the insurance carrier, (ii) employer, (iii) any other entity that is liable for payment for the Covered Services as a primary payor, or (iv) the Member (to the extent such Member has been paid by the carrier, employer, or entity for such Covered Services); and (b) a group health plan or large group health plan, Provider may charge: (i) the group health plan or large group health plan; or (ii) the Member, to the extent that such Member has been paid by either such plan. [42 C.F.R. § 422.108.]
21. **Quality Improvement (QI) Program.** Participating Providers agree to comply with Payor's Quality Improvement Program and the provisions of this Agreement. [42

C.F.R. § 422.202(b)]. Payor is required under the Medicare Advantage Program to have an agreement with an independent quality review and improvement organization approved by CMS to perform an external review of Payor's QI Program. [42 C.F.R. § 422.504(a)(5).] Participating Providers agree to comply with the activities of Payor's independent quality review and improvement organization in accordance with the applicable Medicare Advantage Program requirements, including, without limitation, (a) allocating adequate space at their facilities for use of the review organization whenever it is conducting review activities; and (b) providing all pertinent data, including without limitation, patient care data, at the time the review organization needs the data to carry out the review and make its determination. [42 C.F.R. § 422.152].

22. **Member Grievance and Appeals Procedures.** Participating Providers agree to comply with Payor's procedures for Member grievances, organization determinations, and Member appeals set forth in the Benefit Program Requirements for Benefit Programs under the Medicare Advantage Program, as described in 42 C.F.R. § 422.562, and others, as applicable.

END OF AGREEMENT