New York Addendum

State Specific Provider Requirements

# **General Terms.**

## *Relationship to Master Provider Agreement*.In the event that a provision of this Addendum conflicts with a provision of the Agreement, the provisions of this Addendum shall supersede, govern and control to the extent required by law and to the extent Contigo Health, Provider, Customers, Downstream Clients or Payors are subject to such law.

## *Applicability*. Provisions included herein which are not otherwise addressed by the Agreement shall be considered additional obligations upon the Parties for purposes of Covered Services provided in this State. Provisions included herein which specifically contradict an obligation under a provision of the Agreement shall replace that specific Agreement provision for purposes of Covered Services provided in this State, to the extent necessary to comply with applicable law. The provisions of this Addendum apply only to the entities covered by the referenced law and only for purposes of Covered Services provided in this State, unless otherwise required by the terms of the applicable law.

## *Definitions*. Capitalized terms used herein but not defined shall have the meaning assigned in the Agreement or assigned in the applicable law.

## *Citations*. The citations in this Addendum are current as of the date of this Addendum. Renumbering or recodification of statutes or regulations does not nullify the intent of the applicable provision provided herein.

## *Compliance with Law; Change of Law*. Any ambiguity in this Addendum shall be resolved in favor of a meaning that complies and is consistent with applicable law. To the extent a law cited herein is modified in a manner impacting this Addendum, any required revisions shall be automatically incorporated herein and any provisions which are no longer applicable shall be considered severed from this Addendum effective as of the date of the change in law. Contigo Health will update this Addendum after a change in law when reasonably practicable.

# **Network Arranger Laws**

## As of the date of this Addendum, there are no applicable laws of this type.

# **General Insurance Laws**

## As required by N.Y. Ins. Law § 3217-b(e), the following terms are prescribed in the Agreement, the Provider Manual, or in another item that has been provided to the Provider separately which shall be incorporated into the Agreement: (i) the method by which payments are made to a Provider (including any prospective or retrospective adjustments) shall be calculated, (ii) the time periods within which such calculations will be completed, the dates upon which any such payments and adjustments shall be determined to be due, and the dates upon which any such payments and adjustments will be made; (iii) a description of the records or information relied upon to calculate any such payments and adjustments, and a description of how the Provider can access a summary of such calculations and adjustments; (iv) the process to be employed to resolve disputed incorrect or incomplete records or information and to adjust any such payments and adjustments which have been calculated by relying on any such incorrect or incomplete records or information so disputed; provided, however, that nothing herein shall be deemed to authorize or require the disclosure of personally identifiable patient information or information related to other individual health care providers or the plan's proprietary data collection systems, software or quality assurance or utilization review methodologies; and (v) the right of either party to the Agreement to seek resolution of a dispute arising pursuant to the payment terms through a proceeding under N.Y. C.P.L.R. 75.

## As required by N.Y. Ins. Law § 3217-b(m), Provider must have in place business processes to ensure the timely provision of provider directory information to the insurer. A health care Provider shall submit such provider directory information to an insurer, at a minimum, when a provider begins or terminates a network agreement with an insurer, when there are material changes to the content of the provider directory information of the health care Provider, and at any other time, including upon the insurer's request, as the health care Provider determines to be appropriate.

## As required by N.Y. Ins. Law § 3217-b(n), Provider must reimburse the insured for the full amount paid by the insured in excess of the in-network cost-sharing amount, plus interest at an interest rate determined by the Superintendent in accordance with 42 U.S.C. § 300gg-139(b), for the services involved when the insured is provided with inaccurate network status information by the insurer in a provider directory or in response to a request that stated that the provider was a participating Provider when the provider was not a participating provider. In the event the insurer provides inaccurate network status information to the insured indicating the provider was a participating Provider when such provider was not a participating Provider, the insurer shall reimburse the provider for the out-of-network services regardless of whether the insured's coverage includes out-of-network services.

## To the extent the Agreement contains a financial risk transfer between an insurer and health care provider as described in N.Y. Comp. Codes R. & Regs. tit. 11 § 101.9(a), the Agreement shall contain the following provisions:

### The health care Provider's in-network capitation from the insurer must first be used for medical and hospital services to be rendered by the health care Provider and its participating Providers which derive from the financial risk transfer agreement with the insurer, as well as necessary administrative costs associated with such services;

### The health care Provider agrees that the Superintendent, and the insurer, shall have the right, from time to time, to inspect the health care provider's books and records and that the Superintendent may examine under oath any officer or agent of such provider with respect to its use of the in-network capitation funds received from the insurer and the Provider's compliance with the terms and conditions of the financial risk transfer agreement;

### The health care Provider agrees that on an annual basis, it will submit within 120 days of the close of its fiscal year, to the insurer and the Superintendent, a financial statement in a form prescribed by the Superintendent, sworn to under penalty of perjury by the health care provider's chief financial officer, showing the health care Provider's financial condition at the close of its fiscal year, together with an opinion of an independent certified public accountant (CPA) on the financial statement of such health care Provider. When reviewing the financial condition of the health care Provider the CPA's certification shall represent whether the liabilities of the health care Provider make adequate provision for any additional liability that may insure to the health care Provider by virtue of its assumption of risk under a financial risk transfer agreement or any similar transaction. The amount and adequacy of any such liability (and a description of the procedures used by the CPA to determine such liability) shall be disclosed and commented upon by the CPA in its certification. The CPA shall also test check and report on the safeguards adopted by the health care Provider to ensure its compliance with N.Y. Comp. Codes R. & Regs. tit. 11 § 101.9(a)(1). In rendering the required opinion, the CPA may take into consideration the financial position of a guaranteeing parent corporation, provided that the terms and conditions of such guarantee have been reviewed by the CPA. In such cases, the opinion of the CPA on the health care Provider's financial statement shall state to what extent, if any, the CPA relied upon the guarantee when rendering its opinion and to what extent the CPA reviewed the financial position of the parent corporation. A copy of the consolidated financial statement of the guaranteeing parent corporation for the same fiscal year together with an opinion of an independent CPA on such financial statement shall be attached to the CPA's opinion on the health care Provider's financial statement. Such financial statement and opinion shall be available for public inspection at the office of the superintendent and the principal office of the insurer;

### In-network capitation payments from the insurer to the health care Provider must be made on a monthly basis;

### No payment to the health care Provider shall be made by the insurer prior to the first day of the month for which the payment relates;

### In the event the insurer will be providing administrative services for the health care Provider in conjunction with such Provider's assumption of financial risk, then such services and the resulting charges must be set forth in writing (as part of the financial risk transfer agreement or in a separate agreement) and if such services include the remittance of claim payments due to participating Providers then such payments must be disbursed from the health care Provider's bank account; and

### In addition to any other contractual provision affecting termination of the Agreement, that upon a satisfactory demonstration to the superintendent that the health care provider is not, in a material way, adhering to the terms and conditions of the financial risk transfer agreement, or the provisions of this Part; or that the health care Provider's condition is such that the further transaction of its business will be hazardous to the insurer's subscribers; then with the approval of the superintendent the insurer may make all or part of any monthly in-network capitation payments due under the financial risk transfer agreement into an escrow account approved by the superintendent which amounts shall remain in escrow until such time as the superintendent determines that the health care provider is complying with the terms and conditions of the financial risk transfer agreement; or, after notice and an opportunity to be heard, the superintendent determines (with the advice of the commissioner in the case of an entity possessing a certificate of authority under N.Y. Health Law § 44) that it is in the best interest of subscribers to immediately terminate such agreement. Any determination by the superintendent shall provide for the distribution of the funds held in this escrow account and for the disposition of any financial security deposit.

## As required by N.Y. Comp. Codes R. & Regs. tit. 11 § 101.9(b), the Agreement also incorporates any other provisions required by the Insurance Law or any regulations thereunder and provider contracts entered into by entities certified by article N.Y. Health Law § 44 shall continue to be subject to all the applicable requirements contained in and N.Y. Comp. Codes R. & Regs. tit. 11 § 101.9 and N.Y. Comp. Codes R. & Regs. tit. 10 § 98-1.

# **Health Maintenance Organization (HMO)/Managed Care Organization (MCO) Specific Laws**

## As required by N.Y. Comp. Codes R. & Regs. tit. 10 § 98-1.5(b)(6)(ii), Provider shall hold MCO enrollees harmless from liability, and shall not bill enrollees under any circumstances for the costs of covered services rendered by the contracting Provider, except that nothing herein shall prevent collection of applicable co-payments or co-insurance or permitted deductibles.

## As required by N.Y. Comp. Codes R. & Regs. tit. 10 § 98-1.5(b)(6)(iii), MCO and participating IPAs, as necessary, are allowed access to the medical records of all health care Providers serving the MCO's enrollees provided the consent of the enrollee is first obtained either at the time of initial enrollment or initial visit with a participating Provider.

## As required by N.Y. Comp. Codes R. & Regs. tit. 10 § 98-1.5(b)(6)(iv), if the Agreement is between an MCO and health service Provider, any material change to the Agreement requires prior approval by the commissioner, which shall be submitted in compliance with guidelines issued by the commissioner under N.Y. Comp. Codes R. & Regs. tit. 10 § 98-1.5(b)(6)(v).