

ANCILLARY SERVICES PROVIDER AGREEMENT

THIS ANCILLARY SERVICES PROVIDER AGREEMENT (“Agreement”) is made and entered into as of the effective date set forth on the signature page below (“Effective Date”), by and between _____ (“Provider”) and Granite State Health Plan, Inc. (“MCO”).

WHEREAS, Provider is a provider of _____ services duly licensed and operating in accordance with all applicable State and federal laws and regulations;

WHEREAS, MCO has obtained a certificate of authority to operate a health maintenance organization authorized to arrange for the provision of Covered Services to Covered Persons (as hereinafter defined);

WHEREAS, MCO wishes to contract with Provider to provide certain Covered Services to Covered Persons; and

WHEREAS, Provider desires to provide the Covered Services specified in this Agreement to Covered Persons for the consideration, and under the terms and conditions, set forth in this Agreement.

NOW, THEREFORE, in consideration of the premises and mutual promises herein stated, the parties hereby agree as follows:

ARTICLE I DEFINITIONS

As used in this Agreement and each of its Attachments, each of the following terms (and the plural thereof, when appropriate) shall have the meaning set forth herein.

- 1.1. ***Affiliate(s)*** means a person or entity controlling, controlled by, or under common control with MCO.
- 1.2. ***Attachment(s)*** means the attachments to this Agreement, including addenda and exhibits, all of which are hereby incorporated herein by reference, as set forth in Section 11.15 to this Agreement.
- 1.3. ***Clean Claim*** has, as to each particular product, the meaning set forth in the Attachment pertaining to each such product. If there is no definition for a particular product, “Clean Claim” shall have the meaning set forth in the Provider Manual.
- 1.4. ***Covered Person*** means a person eligible to receive Covered Services and enrolled in a health benefit plan that is issued or administered by MCO, an Affiliate or Payor.

- 1.5. **Covered Services** means those Medically Necessary health care services covered under the terms of the applicable Payor Contract and rendered in accordance with the Provider Manual.
- 1.6. **Emergency or Emergency Care** has, as to each particular product, the meaning set forth in the Attachment pertaining to each such product. If there is no definition for a particular product, Emergency Care shall mean inpatient and outpatient Covered Services furnished by a qualified provider that are needed to evaluate or stabilize an Emergency Medical Condition.
- 1.7. **Emergency Medical Condition** means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.
- 1.8. **Medical Director** means a duly licensed physician or his/her physician designee designated by MCO to monitor and evaluate the appropriate utilization of Covered Services by Covered Persons.
- 1.9. **Medically Necessary** means, unless otherwise defined in the applicable Attachment, any health care services determined by MCO's Medical Director or Medical Director's designee to be required to preserve and maintain a Covered Person's health, provided in the most appropriate setting and in a manner consistent with the most appropriate type, level, and length of service, which can be effectively and safely provided to the Covered Person, as determined by acceptable standards of medical practice and not solely for the convenience of the Covered Person, Covered Person's physician, Provider or other health care provider.
- 1.10. **Participating Health Care Provider** means any physician, hospital, ancillary, or other health care provider that has contracted directly or indirectly with MCO to provide Covered Services to Covered Persons and is credentialed in accordance with the MCO's credentialing criteria.
- 1.11. **Payor** means MCO or another entity that is responsible for funding Covered Services to Covered Persons.
- 1.12. **Payor Contract** means MCO's contract with any Payor that governs provision of Covered Services to Covered Persons. Where MCO is the Payor, "Payor Contract" means MCO's contract with the State or federal agency or other entity that has contracted with MCO to arrange for the provision of Covered Services to eligible individuals of such agency or other entity.

- 1.13. ***Provider Manual*** means the MCO manual of policies, procedures, and requirements to be followed by Participating Health Care Providers. The Provider Manual includes, but is not limited to, utilization management, quality management, grievances and appeals, and Payor-specific program requirements, and may be changed from time to time by MCO.
- 1.14. ***State*** is defined as the state set forth in the Attachment(s) attached hereto.

ARTICLE II

MCO'S OBLIGATIONS

- 2.1. **Administration**. MCO shall be responsible for the administrative activities necessary or required for the commercially reasonable operation of a health maintenance organization. Such activities shall include, but are not limited to, quality improvement, utilization management, grievances and appeals, claims processing, and maintenance of provider directory and records.
- 2.2. **Provider Manual**. MCO shall make the Provider Manual available to Provider via MCO's website and upon Provider's request. MCO shall post changes to the Provider Manual on MCO's website or provide Provider with prior written notice of material changes to the Provider Manual.
- 2.3. **Identification Cards**. MCO or Payor shall issue to Covered Persons an identification card that shall bear the name of the Covered Person, and a unique identification number.
- 2.4. **Benefits and Eligibility Verification**. MCO or Payor, as determined by the Payor Contract, shall be responsible for all eligibility and benefit determinations regarding Covered Services and all communications to Covered Persons regarding final benefit determinations, eligibility, bills, and other matters relating to their status as Covered Persons.
- 2.5. **MCO's Medical Director**. MCO shall provide a Medical Director to be responsible for the professional and administrative medical affairs of MCO.

ARTICLE III

PROVIDER'S OBLIGATIONS

- 3.1. **Covered Services**. Provider shall provide to Covered Persons those Covered Services described in the applicable Attachment(s) in accordance with the Provider Manual and according to the generally accepted standards of medical practice in the Provider's community, the scope of Provider's license, and the terms and conditions of this Agreement. Provider shall make necessary and appropriate arrangements to assure the availability of Covered Services to Covered Persons during business hours consistent with like providers and in accordance with applicable State and federal law and the Payor Contract.

- 3.2. Compliance with MCO Policies and Procedures. Provider warrants that Provider and all persons providing services hereunder on Provider's behalf ("Provider Personnel"), shall at all times cooperate and comply with the policies and procedures of Payor, including, but not limited to, the following:
- A. MCO's credentialing criteria;
 - B. MCO's Provider Manual;
 - C. MCO's medical management program including quality improvement, utilization management, disease management, and case management;
 - D. MCO's grievance and appeal procedures; and
 - E. MCO's coordination of benefits and third party liability policies.
- 3.3. Determination of Covered Person Eligibility. Provider shall verify, in accordance with the Provider Manual, whether an individual seeking Covered Services is a Covered Person. If MCO determines that such individual was not eligible for Covered Services at the time the services were rendered, such services shall not be eligible for payment under this Agreement, and Provider may bill the individual or other responsible entity for such services.
- 3.4. Emergency Care. Provider shall provide Emergency Care in accordance with applicable federal and State laws and the Payor Contract. Provider shall notify MCO within twenty-four (24) hours or by the next business day of rendering or learning of the rendering of Emergency Care to a Covered Person.
- 3.5. Acceptance of New Patients. To the extent that Provider is accepting new patients, Provider must also accept new patients who are Covered Persons of MCO. Provider shall provide MCO forty-five (45) days written notice prior to Provider's decision to no longer accept Covered Persons of MCO or any other Payor. In no event shall any established patient of Provider who becomes a Covered Person be considered a new patient.
- 3.6. Referrals; Reporting to Primary Care Physician. Provider shall provide Covered Services to Covered Persons upon referral from a MCO primary care physician ("PCP") or MCO, and shall arrange for any appropriate referrals and/or admissions of Covered Persons, in accordance with the requirements of the Provider Manual. Provider shall, within a reasonable time following consultation with, or testing of, a Covered Person (not to exceed one (1) week), make a complete written report to the Covered Person's PCP, provided that, with respect to findings which may indicate a need for immediate or urgent follow-up treatment or testing or which may indicate a need for further or follow-up care outside the scope of the referral authorization or outside the scope of Provider's area of expertise, the Provider shall provide an immediate oral report to the Covered Person's PCP, not to exceed twenty-four (24) hours from the time of Provider's consultation or Provider's receipt of the report of the testing, as applicable.

- 3.7. Preferred Drug List/Drug Formulary. If applicable to the Covered Person's coverage, Provider shall abide by MCO's formulary or preferred drug list when prescribing medications for Covered Persons.
- 3.8. Treatment Decisions. MCO shall not be liable for, nor will it exercise control over, the manner or method by which Provider provides or arranges for Covered Services. Provider understands that MCO's determinations, if any, to deny payments for services which MCO does not deem to constitute Covered Services or which were not provided in accordance with the requirements of this Agreement, the Attachments or the Provider Manual, are administrative decisions only. Such a denial does not absolve Provider of Provider's responsibility to exercise independent judgment in Covered Person treatment decisions. Nothing in this Agreement is intended to interfere with Provider's provider-patient relationship with Covered Person(s).
- 3.9. Facilities. Provider agrees that the facilities at which Covered Services are provided hereunder shall be maintained in accordance with all applicable federal and State laws.
- 3.10. Covered Person Communication. Provider shall obtain Payor and MCO's approval for Covered Person communication as required by the Payor Contract and applicable State and federal law. Nothing in this Agreement shall be construed as limiting Provider's ability to communicate with Covered Persons with regard to quality of health care or medical treatment decisions or alternatives regardless of Covered Service limitations under the Payor Contract.
- 3.11. Cooperation with MCO Carve-Out Vendors. Provider acknowledges that MCO may, during the term of this Agreement, carve-out certain Covered Services from its general provider contracts, including this Agreement, as MCO deems necessary to promote the quality and cost-effectiveness of services provided to Covered Persons. Provider shall cooperate with any and all third party vendors that have contracted with MCO or an Affiliate of MCO to provide services to Covered Persons.
- 3.12. Disparagement Prohibition. Provider agrees not to disparage MCO in any manner during the term of this Agreement or in connection with any expiration, termination or non-renewal of this Agreement. Provider shall not interfere with MCO's contractual relationships including, but not limited to, those with other Participating Health Care Providers. Nothing in this provision, however, shall be construed as limiting Provider's ability to inform patients that this Agreement has been terminated or otherwise expired or to promote Provider to the general public or to post information regarding other health plans consistent with Provider's usual procedures, provided that no such promotion or advertisement is directed at any specific Covered Person or group of Covered Persons.
- 3.13. Nondiscrimination. Provider will provide services to Covered Persons without discrimination on account of race, sex, sexual orientation, age, color, religion, national origin, place of residence, health status, type of Payor, source of payment, physical or mental disability or veteran status, and will ensure that its facilities are accessible as

required by Title III of the Americans With Disabilities Act of 1991 (“ADA”). Provider recognizes that as a governmental contractor, MCO is subject to various federal laws, executive orders and regulations regarding equal opportunity and affirmative action, which also may be applicable to subcontractors.

- 3.14. Written Notice. Provider shall give written notice to MCO of: (i) any situation which develops regarding Provider, when notice of that situation has been given to the State agency that licenses Provider, or any other licensing agency or board, or any situation involving an investigation or complaint filed by the State agency that licenses Provider, or any other licensing agency or board, regarding a complaint against Provider’s license; (ii) when a change in Provider’s license to practice medicine is affected or any form of reportable discipline is taken against such license; (iii) suspension or exclusion under a federal health care program, including, but not limited to, Medicaid; (iv) any government agency request for access to records; or (v) any lawsuit or claim filed or asserted against Provider alleging professional malpractice, regardless of whether the lawsuit or claim involves a Covered Person. In any such instance described above, Provider must notify MCO in writing within ten (10) days from the date Provider first receives notice, whether written or oral, with the exception of those lawsuits or claims which do not involve a Covered Person, with respect to which Provider has thirty (30) days to notify MCO.
- 3.15. Use of Name. Provider agrees that MCO may use Provider’s name, address, phone number, type of practice, and an indication of Provider’s willingness to accept additional Covered Persons in MCO’s roster of Participating Health Care Providers and marketing materials.

ARTICLE IV **COMPLIANCE WITH LAW**

- 4.1. Compliance with Law and Payor Contracts. Provider and MCO agree that each party shall carry out its obligations in accordance with terms of the Payor Contract and applicable federal and State laws and regulations, including, but not limited to, the requirements of the Stark law (42 U.S.C. § 1395nn) and applicable federal and State self-referral and fraud and abuse statutes and regulations. If, due to Provider’s noncompliance with law, the Payor Contract or this Agreement, sanctions or penalties are imposed on MCO, MCO may, in its sole discretion, offset sanction or penalty amounts against any amounts due Provider from MCO or require Provider to reimburse MCO for the amount of any such sanction or penalty.
- 4.2. HIPAA Compliance. Provider and MCO shall abide by the administrative simplification provisions of the Health Insurance Portability and Accountability Act (“HIPAA”), its implementing regulations [42 C.F.R. parts 160 and 164] and all other federal and State laws regarding confidentiality and disclosure of medical records and other health and Covered Person information, including safeguarding the privacy and confidentiality of any protected health information (“PHI”) that identifies a particular Covered Person. Provider shall assure its own compliance and that of its business associates with HIPAA.

ARTICLE V
CLAIMS SUBMISSION, PROCESSING, AND COMPENSATION

- 5.1. Claims or Encounter Submission. Provider shall submit to Payor claims or encounters for Covered Services in accordance with the Provider Manual. Payor reserves the right to deny payment to Provider if Provider fails to submit in accordance with the Provider Manual. If applicable based on Provider's compensation arrangement, Provider shall submit encounter data to Payor in a timely fashion, which shall contain such statistical and descriptive medical and patient data and identifying information as specified in the Provider Manual.
- 5.2. Compensation. Payor shall pay Clean Claims from Provider for Covered Services provided to Covered Persons in accordance with the applicable exhibit less any applicable copayments, cost-sharing or other amounts that are the Covered Person's financial responsibility. Provider agrees to accept such payments as payment in full for such Covered Services.
- 5.3. Financial Incentives. Nothing in this Agreement shall, or shall be construed to, create any financial incentive for Provider to withhold Medically Necessary services.
- 5.4. Covered Person Hold Harmless. Provider agrees that in no event including, but not limited to, non-payment by MCO, MCO insolvency, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Covered Person for Covered Services provided pursuant to this Agreement. This provision shall not prohibit collection of any applicable copayments or other amounts that are the Covered Person's financial responsibility. This provision shall survive termination or expiration of this Agreement for any reason, shall be construed for the benefit of Covered Persons, and supersedes any oral or written agreement entered into between the Provider and a Covered Person.
- 5.5. Recoupment Rights. Payor shall have the right to immediately recoup any and all amounts owed by Provider to Payor or any Affiliate against amounts owed by Payor or Affiliate to Provider. Provider agrees that all recoupment and any offset rights under this Agreement shall constitute rights of recoupment authorized under State or federal law and that such rights shall not be subject to any requirement of prior or other approval from any court or other government authority that may now have or hereafter have jurisdiction over Provider.

ARTICLE VI
RECORDS/INSPECTIONS

- 6.1. Medical Records/Advance Directives. Provider shall maintain a complete and accurate permanent medical record for each Covered Person to whom Provider renders services under this Agreement and shall include in that record all reports from Participating Health Care Providers and all documentation required by applicable law, regulations, professional standards and the Provider Manual. Provider shall document in the Covered

Person's medical record whether the Covered Person has executed an advance directive and agrees to comply with all federal and State laws regarding advance directives. Medical records of Covered Persons shall be treated as confidential so as to comply with all federal and State laws and regulations regarding the confidentiality of the patient records.

- 6.2. Records. Provider shall maintain records related to services provided to Covered Persons and provide such medical, financial and administrative information to MCO and State and federal government agencies as may be necessary for compliance by MCO with State and federal law and accreditation standards, as well as for the administration of this Agreement. MCO shall have access at reasonable times to books, records, and papers of the Provider relating to the health care services provided to Covered Persons for Covered Services.
- 6.3. Consent to Release Medical Records. Provider shall obtain Covered Person authorizations relative to the release of medical information required by applicable law to provide MCO or other authorized parties with access to Covered Persons' records.
- 6.4. Access. In accordance with applicable law, Provider shall provide access to Provider's records to the following, including any designee or duly authorized agent:
 - A. Payors, during regular business hours and upon prior notice;
 - B. government agencies, to the extent such access is necessary to comply with regulatory requirements that apply to MCO or Payors; and
 - C. accreditation agencies.

Provider shall provide copies of records at no expense.

- 6.5. Record Transfer. Subject to applicable law and Payor Contract requirements, Provider shall cooperate in the timely transfer of Covered Persons' medical records to any other health care provider at no charge and when required.
- 6.6. On-Site Inspections. Provider agrees that medical office space or its facilities, as applicable, shall be maintained in accordance with applicable federal and State regulatory requirements. Provider shall cooperate in on-site inspections of medical office space by MCO, authorized government officials, and accreditation bodies. Provider shall compile any and all information in a timely manner required to evidence Provider's compliance with this Agreement, as requested by such agency(ies), or as otherwise necessary for the expeditious completion of such on-site inspection.

ARTICLE VII **INSURANCE**

- 7.1. **Provider Insurance.** During the term of this Agreement, Provider shall maintain policies of general and professional liability insurance and other insurance that are necessary to insure Provider, and any other person providing services hereunder on Provider's behalf, against any claim(s) of personal injuries or death alleged or caused by Provider's performance under this Agreement. Such insurance shall include, but not be limited to, tail or prior acts coverage necessary to avoid any gap in coverage. Insurance shall be through a licensed carrier, and in a minimum amount of one million dollars (\$1,000,000) per occurrence, and have an annual aggregate of no less than three million dollars (\$3,000,000) unless a lesser amount is accepted by MCO or where State law mandates otherwise. Provider will provide MCO with at least fifteen (15) days notice of such cancellation, non-renewal, lapse, or adverse material modification of coverage. Upon MCO's request, Provider will furnish MCO with evidence of such insurance.
- 7.2. **Other Insurance.** All parties to this Agreement shall maintain in full force and effect appropriate workers' compensation protection and unemployment insurance as required by law.

ARTICLE VIII **INDEMNIFICATION**

- 8.1. **MCO Indemnification.** Provider agrees to indemnify and hold harmless (and at MCO's request defend) MCO, its Affiliates, officers, employees and agents from and against any and all claims, loss, damages, liability, costs, expenses (including reasonable attorney's fees), judgments, or obligations arising from or in connection with third party claims alleging any negligence or otherwise wrongful act or omissions of Provider, its agents or employees in the performance of Provider's obligations under this Agreement.
- 8.2. **Provider Indemnification.** MCO agrees to indemnify and hold harmless (and at Provider's request defend) Provider, its officers, employees and agents from and against any and all claims, loss, damages, liability, costs, expenses (including reasonable attorney's fees), judgments, or obligations arising from or in connection with third party claims alleging any negligence or otherwise wrongful act or omission of MCO, its agents or employees in the performance of MCO's obligations under this Agreement.

ARTICLE IX **DISPUTE RESOLUTION**

- 9.1. **Informal Dispute Resolution.** Any disputes between the parties arising with respect to the performance or interpretation of this Agreement ("Dispute") shall first be resolved by exhausting the processes available in the Provider Manual, then through good faith negotiations between designated representatives of the parties that have authority to settle the Dispute. If the matter has not been resolved within sixty (60) days of the request for

negotiation, either party may initiate arbitration in accordance with the Arbitration section of this Agreement by providing written notice to the other party.

- 9.2. Arbitration. If a Dispute is not resolved in accordance with the Informal Dispute Resolution section of this Agreement, either party wishing to pursue the Dispute shall submit it to binding arbitration conducted in accordance with the Commercial Arbitration Rules of the American Arbitration Association (“AAA”). In no event may any arbitration be initiated more than one (1) year following the end of the sixty (60) day negotiation period of the Informal Dispute Resolution section of this Agreement. Arbitration proceedings shall be conducted at a mutually agreed upon location within the State. The arbitrators shall have no right to award any punitive or exemplary damages or to vary or ignore the terms of this Agreement and shall be bound by controlling law. Each party shall bear its own costs related to the arbitration except that the costs imposed by the AAA shall be shared equally. The existence of a Dispute or arbitration proceeding shall not in and of itself constitute cause for termination of this Agreement. During an arbitration proceeding, each party shall continue to perform its obligations under this Agreement pending the decision of the arbitrator.

ARTICLE X

TERM AND TERMINATION

- 10.1. Term. This Agreement shall have an initial term of three (3) year(s), commencing on the Effective Date. Thereafter, this Agreement shall automatically renew for terms of one (1) year each. Notwithstanding the foregoing, this Agreement may terminate in accordance with the Termination sections below.
- 10.2. Termination of Agreement. This Agreement may be terminated under any of the following circumstances:
- A. By either party upon one hundred eighty (180) days prior written notice effective at the end of the initial term or at the end of any renewal term;
 - B. By either party upon ninety (90) days prior written notice if the other party is in material breach of this Agreement, except that such termination shall not take place if the breach is cured within sixty (60) days following the written notice;
 - C. Immediately upon written notice by MCO if there is imminent harm to patient health or fraud or malfeasance is suspected;
 - D. Immediately upon written notice by either party if the other party becomes insolvent or has bankruptcy proceedings initiated against it;
 - E. Immediately upon written notice by Provider if MCO loses, relinquishes, or has materially affected its certificate of authority to operate as a health maintenance organization; or

- F. Immediately upon written notice by MCO if Provider fails to adhere to MCO's credentialing criteria, including, but not limited to, if Provider (1) loses, relinquishes, or has materially affected its license to provide Covered Services in the State, (2) fails to comply with the insurance requirements set forth in this Agreement; or (3) is convicted of a criminal offense related to involvement in any Medicare or Medicaid program or has been terminated, suspended, barred, voluntarily withdrawn as part of a settlement agreement, or otherwise excluded from any Medicare or Medicaid program.
- 10.3. Rights and Obligations Upon Termination. Upon termination, the rights of each party hereunder shall terminate, provided, however, that such action shall not release the Provider or MCO of their obligations with respect to: (a) payments accrued to Provider prior to termination; (b) Provider's agreement not to seek compensation from Covered Persons for Covered Services prior to termination; and (c) completion of treatment of Covered Persons who are receiving care until continuation of the Covered Person's care can be arranged by MCO as determined by the Medical Director or as required by applicable law or the Payor Contract. Services provided during continuation of care shall be reimbursed in accordance with the terms of this Agreement.
- 10.4. Survival of Obligations. Any obligations that cannot be fully performed prior to the termination of this Agreement including, but not limited to, obligations in the following provisions set forth in this Section, shall survive the termination of this Agreement: Section 3.12 (Disparagement Prohibition); Article IV (Compliance With Law); Section 5.4 (Covered Person Hold Harmless); Article VI (Records/Inspection); Article VII (Insurance); Article VIII (Indemnification); Article IX (Dispute Resolution); Section 10.3 (Rights and Obligations Upon Termination).

ARTICLE XI **MISCELLANEOUS**

- 11.1. Relationship of Parties. The relationship among the parties is that of independent contractors. None of the provisions of this Agreement are intended to create, or to be construed as creating, any agency, partnership, joint venture, employee-employer, or other relationship.
- 11.2. Conflicts Between Certain Documents. If there is any conflict between this Agreement hereto and the Provider Manual, this Agreement shall control. In the event of any conflict, however, between this Agreement and any Attachment hereto, the Attachment shall be controlling as to the product described in that Attachment. In the event of any conflicts between this Agreement, or any Attachment hereto, and the applicable Payor Contract with respect to what services constitute Covered Services, the Payor Contract shall control.
- 11.3. Assignment; Delegation of Duties. This Agreement is intended to secure the services of and be personal to Provider, and shall not be assigned, sublet, delegated or transferred by Provider without the prior written consent of MCO.

- 11.4. Headings. The headings of the sections of this Agreement are inserted merely for the purpose of convenience and do not, expressly or by implication, limit, define, or extend the specific terms of the section so designated.
- 11.5. Governing Law. All matters affecting the interpretation of this Agreement and the rights and obligations of the parties hereto shall be governed by and construed in accordance with applicable federal and State laws.
- 11.6. Third Party Beneficiary. Except as specifically provided herein, the terms and conditions of this Agreement shall be for the sole and exclusive benefit of Provider and MCO. Nothing herein, express or implied, is intended to be construed or deemed to create any rights or remedies in any third party.
- 11.7. Amendment. This Agreement, including all Attachments, may be amended at any time by mutual written agreement of the parties. This Agreement and any of its Attachments may also be amended by MCO furnishing Provider with any proposed amendments. Unless Provider objects in writing to such amendment during the thirty (30) day notice, Provider shall be deemed to have accepted the amendment. Notwithstanding the foregoing, this Agreement shall be automatically amended as necessary to comply with any applicable State or federal law or regulation and applicable provision of the Payor Contract.
- 11.8. Entire Agreement. This Agreement, its Attachments, and the Provider Manual contain all the terms and conditions agreed upon by the parties and supersede all other agreements, oral or otherwise, of the parties hereto, regarding the subject matter of this Agreement.
- 11.9. Severability. The invalidity or unenforceability of any terms or provisions hereof shall in no way affect the validity or enforceability of any other terms or provisions.
- 11.10. Waiver. The waiver by either party of the violation of any provision or obligation of this Agreement shall not constitute the waiver of any subsequent violation of the same or other provision or obligation.
- 11.11. Notices. Any notice required to be given pursuant to the terms and provisions hereof shall be in writing and shall be sent by certified mail, return receipt requested, postage prepaid, or by recognized courier service, addressed as follows:

To MCO at:
 Attn: President
 Granite State Health Plan, Inc.

To Provider at:
 Attn: _____

or to such other address as either party may designate in writing.

11.12. Force Majeure. Neither party shall be liable or deemed to be in default for any delay or failure to perform any act under this Agreement resulting, directly or indirectly, from acts of God, civil or military authority, acts of public enemy, war, accidents, fires, explosions, earthquake, flood, strikes or other work stoppages by either party's employees, or any other similar cause beyond the reasonable control of such party.

11.13. Confidentiality. Neither party shall disclose the substance of this Agreement nor any information acquired from the other party during the course of or pursuant to this Agreement to any third party, unless required by law. Provider acknowledges and agrees that all information relating to MCO's programs, policies, protocols and procedures is proprietary information and further agrees not to disclose such information to any person or entity without MCO's express written consent.

11.14. Authority. The parties whose signatures are set forth below represent and warrant that they are duly empowered to execute this Agreement.

11.15. Attachments. Each of the Attachments below is hereby made part of this Agreement:

Attachment A – State Mandated Provisions

Attachment B – Product Attachment

Exhibit 1 – Ancillary Compensation Schedule

[SIGNATURE BLOCK FOLLOWS]

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

IN WITNESS WHEREOF, the parties hereto have executed this Agreement effective as of the date set forth below.

MCO:

Provider:

Granite State Health Plan, Inc.

Authorized Signature

Authorized Signature

Printed Name:

Printed Name:

Title:

Title:

Signature Date:

Signature Date:

Effective Date of Agreement:

(To be completed by MCO only)

Tax Identification Number:

National Provider Identifier:

State Medicaid Number:

To be completed by MCO only:

Effective Date of Agreement:

ATTACHMENT A

STATE MANDATED PROVISIONS

This Attachment A, State-Mandated Provisions, (“Attachment A”) is incorporated into the Ancillary Services Provider Agreement (“Agreement”) entered into by and between _____ (“Provider”) and Granite State Health Plan, Inc. (“MCO”). MCO and Provider shall comply with the following provisions, which are required by State law to be included in this Agreement, to the extent applicable and as such, provisions may be amended from time to time.

ARTICLE I RECITALS

- 1.1 This Attachment A is intended to supplement this Agreement by setting forth those provisions required by State law and regulations to be included in a participation agreement between MCO and providers. In the event of a conflict between the terms and conditions of this Agreement or Product Attachment and the terms and conditions of this Attachment A, this Attachment A shall govern. This Attachment A shall apply only with respect to those Products providing coverage for Covered Persons who are residents of the State.
- 1.2 Provider agrees and understands that Covered Services shall be provided in accordance with State laws and regulations. To the extent Provider is unclear about Provider’s duties and obligations, Provider shall request clarification from MCO.

ARTICLE II DEFINITIONS

For purposes of this Attachment A, the following terms shall be defined as set forth below. Capitalized terms not defined below shall have the same meaning set forth in the Agreement. The definitions listed below will supersede any meanings contained elsewhere in this Agreement and any Product Attachment.

- 2.1 ***Covered Person*** means a policyholder, subscriber, enrollee, or other individual participating in MCO’s health benefit plan.
- 2.2 ***Medically Necessary*** means health care services or products provided to a Covered Person for the purpose of preventing, stabilizing, diagnosing, or treating an illness, injury, or disease or the symptoms of an illness, injury or disease in a manner that is (i) consistent with generally accepted standards of medical practice; (ii) clinically appropriate in terms of type, frequency, extent, site and duration; (iii) demonstrated through scientific evidence to be effective in improving health outcomes; (iv) representative of the “best practices” in the medical profession; and (v) not primarily for the convenience of the Covered Person or physician or other health care provider.

2.3 *State* means the State of New Hampshire.

ARTICLE III **PROVIDER OBLIGATIONS**

- 3.1 Provider agrees that in no event including, but not limited to, non-payment by MCO, MCO insolvency, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Covered Person or a person acting on behalf of the Covered Person (other than the health carrier or intermediary) for Covered Services provided pursuant to this Agreement. This provision shall not prohibit collection of any applicable copayments or other amounts that are the Covered Person's financial responsibility, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to Covered Persons, nor does this Agreement prohibit Provider and a Covered Person from agreeing to continue services solely at the expense of the Covered Person, as long as Provider has clearly informed the Covered Person that MCO may not cover or continue to cover a specific service or services. Except as provided in this chapter, this Agreement does not prohibit Provider from pursuing any available legal remedy. This provision shall survive termination or expiration of this Agreement for any reason, shall be construed for the benefit of Covered Persons, and supersedes any oral or written agreement entered into between Provider and a Covered Person.
- 3.2 Changes to Fee Schedule. No material change to an applicable fee schedule attached hereto shall be effective upon fewer than sixty (60) days notice, unless otherwise required under applicable law or the parties agree to an earlier effective date.
- 3.3 Provider Participation in Grievance Process. MCO shall not remove Provider from MCO's network, or refuse to renew this Agreement, because of Provider's participation in a Covered Person's internal grievance process and/or external review process.
- 3.4 Continuation of Care upon Termination. In the event this Agreement is terminated for any reason other than Provider's unprofessional behavior, Provider shall, for a period of sixty (60) days from the date of such termination, continue to provide Covered Services to Covered Persons. The parties hereby acknowledge that the Covered Services provided to Covered Persons during this time shall be provided and paid for in accordance with the terms and conditions of the Covered Person's benefit plan and this Agreement.
- 3.5 Modifications to Agreement. Provider hereby acknowledges that Provider was allowed at least sixty (60) days from the postmarked date to review this Agreement as proposed.
- 3.6 Provider Referral. With respect to the provision of Covered Services hereunder, a Provider that is employed by a hospital or any affiliate is not required or in any way obligated to refer patients to providers also employed or under contract with the hospital or any affiliate.

3.7 Contract. Provider hereby acknowledges that Provider has received a complete copy of the proposed contract, including all attachments and exhibits, and the most current provider manual has been made available to Provider.

ATTACHMENT B

NEW HAMPSHIRE MEDICAID PRODUCT ATTACHMENT

This New Hampshire Medicaid Product Attachment (the “*Product Attachment*”) is incorporated into the [REDACTED] Agreement (the “*Agreement*”) entered into by and between [REDACTED] (in this Product Attachment referred to as “*Provider*”), and [REDACTED] (“*MCO*”).

ARTICLE I RECITALS

- 1.1 MCO has contracted with the New Hampshire Department of Health and Human Services (“*DHHS*”) to arrange for the provision of medical services to Covered Persons under the New Hampshire Medicaid Program (“*New Hampshire Medicaid Program*”).
- 1.2 Provider has entered into this Agreement with MCO. This Product Attachment is intended to supplement this Agreement by setting forth the parties’ rights and responsibilities related to the provision of Covered Services to Covered Persons as it pertains to the Medicaid Program. In the event of a conflict between the terms and conditions of this Agreement and the terms and conditions of this Product Attachment, this Product Attachment shall govern.
- 1.3 Provider agrees and understands that Covered Services shall be provided in accordance with the contract between DHHS and MCO (“*State Contract*”), the Provider Manual, any applicable State handbooks or policy and procedure guides, and all applicable State and federal laws and regulations. To the extent Provider is unclear about Provider’s duties and obligations, Provider shall request clarification from MCO.

ARTICLE II DEFINITIONS

The definitions listed below will supersede any meanings contained elsewhere in this Agreement with regard to this Product Attachment.

- 2.1 *PCP* means a Participating Health Care Provider who has the responsibility for supervising, coordinating, and providing primary health care to Covered Persons, initiating referrals for specialist care, and maintaining the continuity of member care. PCPs include, but are not limited to Pediatricians, Family Practitioners, General Practitioners, Internists, Obstetricians/Gynecologists, Physician Assistants (under the supervision of a physician), or Advanced Registered Nurse Practitioners, as designated by the MCO. The definition of PCP is inclusive of primary care physician as it is used in 42 CFR 438.
- 2.2 *State* means the state of New Hampshire.

ARTICLE III
PROVIDER OBLIGATIONS

- 3.1 Provider shall participate, as necessary, in the development of a system of care model for children with serious emotional disturbance.
- 3.2 Provider, as applicable, shall provide Early and Periodic Screening, Diagnostic and Treatment (“*EPSDT*”) visits to Covered Persons less than 21 years of age according to the periodic schedule approved by DHHS. Such visit shall include a comprehensive history, unclothed physical examination, appropriate immunizations, lead screenings and testing per Center for Medicare and Medicaid Services (“*CMS*”) requirements. Provider shall comply with MCO’s *EPSDT* Plan as required pursuant to DHHS requirements.
- 3.3 Provider shall provide Covered Services to Covered Persons of all cultures, races, ethnic backgrounds, and religions in a manner that recognizes values, affirms and respects the worth of the Covered Person and protects and preserves the dignity of each.
- 3.4 Provider shall ensure that Medically Necessary services are available to Covered Persons twenty-four (24) hours a day, seven (7) days a week.
- 3.5 Provider’s hours of operation shall be no less than the hours of operation offered to commercial and fee-for-service patients.
- 3.6 Provider shall provide Covered Services on a timely basis in accordance with medically appropriate guidelines consistent with generally accepted standards of care.
- 3.7 Provider shall ensure that the waiting times for appointments do not exceed the following:
 - A. Transitional healthcare from a primary, specialty, or approved community mental health provider for clinical assessment and care planning shall be provided within seven (7) calendar days of discharge from inpatient or institutional care for physical or behavioral health disorders or discharge from a substance use disorder treatment program.
 - B. Transitional healthcare from a home health nurse or a registered counselor shall be provided within two (2) calendar days of discharge from inpatient or institutional care for physical or behavioral health disorders or discharge from a substance use disorder treatment program, if ordered by the Covered Person’s PCP or specialty care provider or as part of the discharge plan.
 - C. Non-symptomatic (i.e., preventive care) office visits from Covered Person’s PCP or another provider shall be provided within thirty (30) calendar days; A non-symptomatic office visit may include, but is not limited to, well/preventive care such as physical examinations, annual gynecological examinations, or child and adult immunizations.

- D. Non-urgent, symptomatic (i.e., routine care) office visits from Covered Person's PCP or another provider shall be provided within ten (10) calendar days. A non-urgent, symptomatic office visit is associated with the presentation of medical signs not requiring immediate attention.
 - E. Urgent, symptomatic office visits from the Covered Person's PCP or another provider shall be provided within forty-eight (48) hours. An urgent, symptomatic visit is associated with the presentation of medical signs that require immediate attention, but are not life threatening and do not meet the definition of Emergency Medical Condition.
 - F. Emergency medical and psychiatric care shall be provided within twenty-four (24) hours per day, seven (7) days per week.
 - G. If applicable, behavioral health care shall be available as follows:
 - i. within six (6) hours for a non-life threatening emergency;
 - ii. within forty-eight (48) hours for urgent care; or
 - iii. an appointment within ten (10) business days for a routine office visit.
- 3.8 Provider shall accept Covered Person's Medicaid identification card as proof of enrollment in the MCO until the Covered Person receives his/her MCO identification card.
- 3.9 Provider shall participate in MCO's provider training within thirty (30) calendar days of the Effective Date of the Agreement.
- 3.10 Provider represents and warrants that it is currently licensed and/or certified in the State to provide Covered Services. Provider further represents and warrants that it is not under sanction or exclusion from the federal Medicaid program. Provider acknowledges that it has a National Provider Identifier (NPI) in accordance with the timelines established in 45 C.F.R. Part 162, Subpart D and is enrolled as a State Medicaid provider.
- 3.11 Provider shall cooperate with MCO's Quality Assessment and Performance Improvement Program.
- 3.12 Provider shall report encounter records in an accurate and timely fashion.
- 3.13 Provider will fully cooperate with federal and State agencies in any investigations and/or subsequent legal actions.
- 3.14 Provider represents that it is not debarred, suspended, or otherwise excluded from participating in federal procurement activities and does not have an employment, consulting or other agreement with a debarred individual for the provision of items or services that are significant to the MCO's contractual obligations with the State.

- 3.15 Provider shall comply with the requirements of the Americans with Disabilities Act (ADA) when providing Covered Services to Covered Persons. Provider shall participate in a standard survey document developed by the State and administered by MCO to determine Provider's compliance with the ADA.
- 3.16 Provider shall comply with the Civil Rights Act of 1964 (42 U.S.C. § 2000d), Title IX of the Education Amendments of 1972 (regarding education programs and activities), the Age Discrimination Act of 1975, the Rehabilitation Act of 1973, the regulations (45C.F.R. Parts 80 & 84) pursuant to that Act, and the provisions of Executive Order 11246, Equal Opportunity, dated September 24, 1965, and all rules and regulations issued thereunder, and any other laws, regulations, or orders which prohibit discrimination on grounds of age, race, ethnicity, mental or physical disability, sexual or affectional orientation or preference, marital status, genetic information, source of payment, sex, color, creed, religion, or national origin or ancestry.
- 3.17 Provider shall not discriminate against eligible members because of race, color, creed, religion, ancestry, marital status, sexual orientation, national origin, age, sex, physical or mental handicap in accordance with Title VI of the Civil Rights Act of 1964, 42 U.S.C. § 2000d, Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794, the Americans with Disabilities Act of New Hampshire Medicaid Care Management Contract 1990 (ADA), 42 U.S.C. § 12131 and rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulation.
- 3.18 Provider shall not discriminate against eligible persons or Covered Persons on the basis of their health or mental health history, health or mental health status, their need for health care services, amount payable to the MCO on the basis of the eligible person's actuarial class, or pre-existing medical/health conditions.
- 3.19 Provider shall ensure that there is coordination between the PCP and the community mental health program.
 - A. Provider shall ensure that both the PCP and community mental health program request written consent from the Covered Person to release information to coordinate care regarding mental health services or substance abuse services or both, and primary care.
 - B. Provider shall provide documentation of all instances in which consent was not given, and if possible the reason why, and submit this report to MCO no later than thirty (30) calendar days following the end of the fiscal year.

EXHIBIT 1
ANCILLARY COMPENSATION SCHEDULE - MEDICAID

For Covered Services provided to Covered Persons, Payor shall pay Provider the lesser of: (i) the Provider's Allowable Charges; or one hundred percent (100%) of the current State Medicaid fee schedule in effect on the date of service and specific to the services rendered.

Additional Provisions:

1. Code Change Updates. Updates to billing-related codes (e.g., CPT, HCPCS, ICD-9, DRG, and revenue codes) shall become effective on the date ("Code Change Effective Date") that is the later of: (i) the first day of the month following thirty (30) days after publication by the governmental agency having authority over the applicable product of such governmental agency's acceptance of such code updates; or (ii) the effective date of such code updates, as determined by such governmental agency. Claims processed prior to the Code Change Effective Date shall not be reprocessed to reflect any code updates.
2. Fee Change Updates. Updates to such fee schedule shall become effective on the date ("Fee Change Effective Date") that is the later of: (i) the first day of the month following thirty (30) days after publication by the governmental agency having authority over the applicable product of such governmental agency's acceptance of such fee schedule updates; or (ii) the effective date of such fee schedule updates, as determined by such governmental agency. Claims processed prior to the Fee Change Effective Date shall not be reprocessed to reflect any updates to such fee schedule.
3. Payment under this Exhibit. All payments under this Exhibit are subject to the terms and conditions set forth in the Agreement, the Provider Manual and the Billing Manual.

Definitions:

1. **Allowable Charges** means those Provider billed charges for services that qualify as Covered Services.