SPECIAL PROVISIONS RELATED TO MEDICAID & HARP MEMBERS

With respect to services rendered to the Plan's Medicaid and Health and Recovery Program (HARP) members (jointly referred to as "Medicaid Members"), Practitioner will be subject to all relevant obligations and duties imposed under the Plan's Medicaid contracts with the New York State Department of Health (NYSDOH) and the New York City Department of Health and Mental Hygiene ("NYC DOHMH"), including the following provisions which shall apply and be binding upon the Parties. These are general guidelines and are not intended to supersede any sound clinical judgment as to the necessity for care and services on a more expedient basis, when judged clinically necessary and appropriate.

A. Plan and Practitioner acknowledge and agree that the Plan's Medicaid Members are not subject to Medicaid utilization thresholds, or limitations on services covered by Medicaid. However, Medicaid Members may be subject to Medicaid utilization thresholds for outpatient pharmacy services that are billed Medicaid fee-for-service until such time as the Plan is required to manage and pay for such services (the Medicaid Pharmacy Carve-In Effective Date).

B. Plan and Practitioner acknowledge and agree that, with respect to the Plan's Medicaid Members, Plan and Practitioner shall comply with the informed consent procedures for hysterectomy and sterilization, as set forth at 42 C.F.R, Part 441, sub-part F and 18 N.Y.C.R.R. Section 505.13, the NYSDOH C/THP Manual and all applicable public health laws and regulations including, without limitation, the reporting of communicable diseases. Practitioner acknowledges and agrees that compliance with this provision shall be audited by Plan and the Plan in connection with its quality assurance review of Practitioner.

C. Plan and Practitioner acknowledge and agree that, with respect to the Plan's Medicaid Members, the Plan retains the right to audit Practitioner's claims for a six (6) year period from the date of care, services or supplies were provided or billed, whichever is later and to recoup any overpayments discovered as a result of the audit. This six (6) year limitation does not apply to situations in which fraud may be involved or in which the Practitioner or an agent of the Practitioner prevents or obstructs the Plan's auditing. Effective July 1, 2007, this policy also applies to recovery of overpayments to provider for Child Health Plus Members.

D. Practitioners treating Members enrolled in Medicaid agree and acknowledge that they must comply with the following guidelines for member-to-provider ratios, which are based on the assumption that the Practitioner practices full-time (forty (40) hours per week). These ratios are practitioner-specific and must be prorated for practitioners practicing less than forty (40) hours per week. The ratios apply to practitioners, not to each of their practice locations.

1. Practitioners who are physicians shall have no more than 1,500 Members on their panel or 2,400 for a physician practicing in combination with a registered physician assistant or certified nurse practitioner.

2. Advanced Nurse Practitioners credentialed as Primary Caregivers shall have no more than 1,000 Members on their panel.

E. Practitioner acknowledges and agrees that the provisions set forth in the Agreement regarding prior approval of elective services shall not apply to the Plan's Medicaid Members seeking services to which Members may self-refer to Family Planning and Reproductive Health Services, including without limitation, pre and post–test HIV counseling and blood testing.

F. Nothing contained in the Agreement shall limit or terminate the Plan's obligations under its Medicaid contracts with NYSDOH or NYCDOHMH or be deemed to impair the rights of NYSDOH or NYCDOHMH, HRA or the Department of Health and Human Services ("DHHS") nor shall any provision contained in the Agreement be deemed to create or imply a contractual relationship between Practitioner and NYSDOH, NYCDOHMH, HRA or LDSSs.

G. In the event that any duty or obligation imposed on Practitioner in this Agreement is deemed to be inconsistent with the provisions set forth in the Plan's Medicaid contracts with NYSDOH or NYCDOHMH, the Medicaid contract duty and obligation shall govern and the duty or obligation as stated in this Agreement shall be unenforceable by the Plan and shall be void and of no effect to the extent that such duty or obligation applies to Practitioner's arranging for the provision of services to Medicaid Members.

H. Welfare Reform: Practitioner serving as a PCP shall provide or arrange for the provision of medical documentation and health, mental health and alcohol and substance abuse assessments as follows:

1. Within ten (10) days of a request from a Medicaid Member or a former Member currently receiving public assistance, or who is applying for public assistance, Practitioner shall provide, as appropriate, medical documentation concerning the Member's or former Member's health or mental health status to the HRA, LDSSs or to their designees. Medical documentation includes, but is not limited to, drug prescriptions and PCP or specialty provider reports.

2. Within ten (10) days of a request from a Member, who has already undergone or is scheduled to undergo, an initial required mental and/or physical examination, Practitioner shall provide or arrange a health or mental health and/or alcohol and substance abuse assessment, mental and/or medical examination or other services as appropriate to identify or quantify the Member's level of incapacitation. Such assessment must contain a specific diagnosis resulting from any medically appropriate tests and specify any work limitations. HRA or LDSSs may, upon written notice, specify the format and instructions for such an assessment.

I. Practitioner agrees to comply with the following guidelines for appointment availability:

1. For emergency care: immediately upon presentation at a service delivery site.
2. For urgent care: within twenty-four (24) hours of request.
3. Non–urgent sick visit: within forty-eight (48) to seventy-two (72) hours of request, as clinically indicated.
4. Routine appointments: within four (4) weeks of request.
5. Specialist referrals (not urgent): within four (4) to six (6) weeks of request.
6. Initial prenatal visit: within three (3) weeks during first trimester, two (2) weeks during the second trimester and one (1) week thereafter.
7. Adult baseline and routine physicals: within twelve (12) weeks from enrollment. Adults are Members over twenty-one (21) years of age.
8. Well–child care: within four (4) weeks of request.
9. Initial family planning visits: within two (2) weeks of request.
10. In-plan mental health or substance abuse follow-up visits (pursuant to an emergency or hospital discharge): within five (5) days of request or as clinically indicated.
11. In-plan, non-urgent mental health or substance abuse visits: within two (2) weeks of request.
12. Initial PCP office visit for newborns: within two (2) weeks of hospital discharge.
13. Accommodate Member visits to Practitioner within ten (10) days of the request by a Member to make health, mental health and substance abuse assessments for the purpose of making recommendations regarding a Member's ability to perform work when requested by an LDSS.

J. Participating Providers who wish to let their patients know of their affiliations with one or more Managed Care Organizations (MCOs) must list each MCO with whom they have contracts.

K. Participating Providers who wish to communicate with their patients about managed care options must advise patients, taking into consideration ONLY the managed care options that best meet the health needs of the patients. Such advice, whether presented verbally or in writing, must be individually based and not merely a promotion of one MCO over another.

L. Participating Providers may display the Plan's outreach materials provided that appropriate material is conspicuously posted for all other MCOs with whom the Participating Provider has a contract.

M. Upon termination of a Provider Agreement with EmblemHealth, a Participating Provider who has contracts with other MCOs that offer Medicaid products may notify their patients of the change in status and the impact of such change on the patient.

N. Participating providers are required to have procedures in place to identify and determine the exclusion status of managing employees through routine checks of Federal databases. These include the Social Security Administration's Death Master file, The National Plan and Provider Enumeration System (NPPES), The Excluded Parties List System (EPLS), either the List of Excluded Individuals and Entities or the Medicare Excluded Database (MED), and any such other databases as the Secretary may prescribe; ii) check the LEIE (or the MED), the EPLS, the U.S. Department of the Treasury's Office of Foreign Assets Control (OFAC) Sanctions List and the NYS OMIG Exclusion list no less frequently than monthly.

O. Provider furnishing items and services to, or ordering, prescribing, referring, or certifying eligibility for, services for individuals eligible to receive Medicaid, HARP and Child Health Plus agrees to enroll in the NYS Medicaid Program if provider type or specialty is listed on Exhibit B to this Amendment by completing and filing the designated enrollment applicable and providing the required information necessary for enrollment. In the event a Provider is terminated from, not accepted to, or fails to submit a designated enrollment applicable to, the NYS Medicaid Program, Provider shall be terminated from participating as a provider in any network that services individuals eligible to receive Medicaid, HARP or Child Health Plus.

Providers Who Are Required to Enroll in the Fee For Service Medicaid Program

If Provider treats EmblemHealth's Medicaid, HARP and/or Child Health Plus, the New York State Department of Health (NYSDOH) has mandated that the following provider types and specialties must enroll in the Fee For Service Medicaid Program on https://www.emedny.org/info/ProviderEnrollment/index.aspx.

- Adult Day Health Care Provider (ADHC)
- Ambulatory Surgery Center (ASC)
- Assisted Living Program (ALP)
- Audiologist
- Bridges to Health Waiver Provider (B2H)
- Care at Home Waiver Provider (CAH)
- Case Management Provider (CMCM)
- Certified Asthma Educator (CAE)
- Certified Diabetes Educator (CDE)
- Chemical Dependency Program (CDP)
- Child (Foster) Care Agency (CCA)
- Children's Health and Behavioral Transformation
- Chiropractor
- Clinic, Diagnostic & Treatment Center (D&TC)
- Clinical Psychologist
- Clinical Social Worker (CSW)
- Consumer Directed Personal Assistance Program (CDPAP) & (CDPAP-FI) Fiscal Intermediary
- Dental Group
- Dentist
- Durable Medical Equipment Supplier (DME)
- Early Intervention Program Provider (EI)
- Eye Prosthesis Supplier/Occularist
- Freestanding Clinic (D&TC)
- Harm Reduction Services
- Health Homes
- Hearing Aid Supplier (HAID)
- Hemodialysis Center (freestanding) (HDC)
- Home Health Agency (HHA)
- Hospice Provider
- Hospital (Inpatient & Outpatient)
- Intermediate Care Facilities for Individuals with Intellectual Disabilities - OPWDD (ICF/IID)
- Laboratory (LAB)
- Laboratory Director (LBD)
- Long Term Home Health Care Program (LTHHCP)
- Managed Care Plan (MCP)
- Midwife/Nurse Midwife
- Nurse (LPN/RN)
- Nurse Practitioner
- Nurse Registry
- Nursing Home - RHCF
- Nursing Home Transition/Diversion (NHTD)
- OASAS Part 820 Residential Treatment Program
- OMH Community Residence
- OMH Licensed ACT Provider

- OMH Licensed Outpatient Provider
- OMH Licensed PROS Provider
- OMH Lic. Residential Treatment Facility (RTF)
- Optical Establishment
- Optician/Opthalmic Dispenser (OPD)
- Optometrist (OPT)
- OPWDD Community Residence
- OPWDD Waiver Provider
- Personal Care Agency (PCA)
- Personal Emergency Response Provider (PERS)
- Pharmacy
- Physician
- Practitioner Groups
- Physician Assistant (Registered)
- Podiatrist
- Portable X-Ray Provider
- School Supportive Health Service Provider (SSHSP)
- Service Bureau
- Supervising Pharmacist
- Therapist (PT, OT, Speech)
- Transportation Provider
- Traumatic Brain Injury