ALLIANCE CARE MANAGEMENT IPA
LHCSA MEDICAL SERVICES PROVIDER AGREEMENT

Agreement is entered into between Alliance Care Management IPA ("ACM IPA") with its principal place of business at 755 Second Avenue, New York, NY 10017 and _____a licensed home health care organization("LHSCA")With offices at_____ effective as of _____2012 (effective date)

WHEREAS, IPA is an independent practice association as defined in 10 NYCRR 98-1.2(w) which arranges for the provision of health care services to Members of a contracted MCO through contracts with New York State licensed, certified, or otherwise lawfully qualified Providers who practice their professions in the State of New York;

WHEREAS, IPA may contract with MCOs certified under Article 44 of the New York Public Health Law as health maintenance organizations, managed long term care plans ("MLTC"), prepaid health services plans and/or HIV special needs plans to provide for health care services covered under applicable Benefit Plans maintained by a MCO;

WHEREAS, LHSCA is licensed, certified or otherwise lawfully qualified to provide health care services and/or home and community based services; and

WHEREAS, IPA and LHSCA mutually desire that LHSCA participate in IPA's provider network and provide Covered Services to Members of those MCOs with which IPA has contracted.

NOW, THEREFORE, in consideration of the premises and mutual promises herein, the sufficiency of which is hereby acknowledged, the parties agree as follows:

PURPOSE

This AGREEMENT is to serve as a covenant for the provision of Paraprofessional Services (as such term is defined by New York Public Health Law §3602(4)) by LHSCA to MCO members Under this AGREEMENT, at IPA or MCO specific request, LHSCA shall provide qualified, competent home health care personnel and arrange for the for the provision of Paraprofessional Services to aid MCO in meeting its members/patients' home health care needs.

SECTION I - Definitions

As used in this Agreement, terms will have the following meanings.

1.1 Benefit Plan/Plan: Those plans offered by MCO under which a Member may receive Covered Services through an LHSCA.

1.2 Care Manager: In accordance with an MCO Program, a MCO designated nurse, social worker, or rehabilitation therapist who, through a Plan of Care, authorizes and oversees the provision of services to a Member through care management, including but not limited to the provision of Covered Services by a LHSCA, including admission and discharge from facility Providers. For purposes of this agreement "Care Management" will mean the implementation of a written Plan of Care, authorized by the MCO, for the purpose of assisting Members to access Covered Services. Care Management also includes referral to, and coordination of, necessary medical, social, educational, psychosocial, financial and other services regardless of whether such services are covered by the MCO.

1.3 Claim: A statement of services submitted to MCO or IPA, as applicable, by LHSCA following the provision of Covered Services according to the Plan of Care, to a Member, which includes an itemization of services and treatment rendered in an electronic format acceptable to MCO or IPA, or the delegate, as applicable, and generally used by like Providers for submitting such claims.

1.4 Clean Claim: An accurate (no erroneous or conflicting information) Claim that has no defect, impropriety, lack of required substantiating documentation or particular circumstance requiring special treatment that prevents timely payment, and contains all of the elements set forth in 11 NYCRR Part 217, as amended from time to time.

1.5 Covered Service(s): Those Medically Necessary long term care services, which LHSCA is qualified to provide, and which MCO is obligated to cover according to the MCO member benefits.

1.6 DOH: New York State Department of Health.

1.7 Effective Date: That date on which IPA has completed credentialing of LHSCA, as set forth on the signature page hereto at such time as the Agreement is countersigned by IPA.

1.8 MCO(s): An entity certified under Article 44 of the New York Public Health Law with whom IPA has contracted as of the Effective Date, or at any time throughout the Agreement, to provide an LHSCA network to Members of the MCO. For purposes of

this Agreement, MCO shall include any entity to which MCO has delegated any MCO function under this Agreement. Managed Care Organization "or "MCO" shall mean the person, natural or corporate, or any groups of such persons, certified under Public Health Law Article 44, who enter into an arrangement, agreement or plan or any combination of arrangements or plans which provide or offer a comprehensive health services plan.

1.9 MCO Contract(s): The Agreement between IPA and the MCO(s) under which IPA provides a LHSCA network to MCO.

1.10 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.

1.11 LHSCA: A Licensed Home Care Services Agency which is licensed, registered and/or certified as required by applicable federal and state law, that has contracted with IPA to become part of the LHSCA network, and to provide Covered Services according to a Plan of Care, to Members of a MCO.

1.12 Medically Necessary or Medical Necessity: Treatment for a particular condition, which is determined by MCO to be required and appropriate in accordance with the definition of medical necessity or medically necessary treatment under State and Federal law and in accordance with acceptable standards of medical practice.

1.13 Member or Patient: Any individual eligible for health care services under a Benefit Plan established, administered and/or maintained by MCO.

1.14 MLTC Program/MLTCP: A program for Medicaid recipients who are eligible for admission to a nursing home, are chronically ill or have disabilities and who need health and long-term care services, such as home care or adult day care, permitting them to stay in their homes and communities as long as possible. The MLTC plan arranges and pays for a large selection of health and social services, and provides choice and flexibility in obtaining needed services from one place.

1.15 Payor: The Centers for Medicare and Medicaid Services ("CMS"), the applicable State or county Medicaid agency, or other agency or entity, as applicable in accordance with Section 3.1 below, with which MCO contracts to arrange for the provision of health care services to applicable Members.

1.16 Payor Contract: MCO's contracts as of the Effective Date or subsequently entered into and added to this Agreement in accordance with Section 2.1 below, with (i) CMS covering certain persons eligible for Medicare under Title XVIII of the Social Security Act, (ii) the applicable State or county agencies covering certain persons eligible for Medicaid under Titles XIX of the Social Security Act and applicable State law, and (iii) any other agency or entity covering individuals eligible for health care expense coverage.

1.17 Plan of Care: In accordance with an MCO MLTC Program, the written plan of care approved by MCO, which includes but is not limited to a description of the Covered Services to be provided to a Member enrolled in the MCO. The Plan of Care will include the amount, frequency and duration of Covered Services to be provided to the Member enrolled in the Program.

1.18 Provider: A health care professional, agency or other entity engaged in the delivery of health care services that is licensed, registered and/or certified as required by applicable Federal and State law. For the purpose of this agreement provider may be referred to LHSCA, LHSCA, Provider, Network Provider

1.19 Quality Improvement: Processes designed and maintained by IPA and/or MCO to monitor and evaluate the quality and appropriateness of care rendered, pursue opportunities to improve care, and resolve identified problems in the quality and delivery of care, as more fully set forth in the Policies.

1.20 Utilization Management: Processes designed and maintained by IPA and/or MCO, or their duly appointed and authorized designees, for determining on a prospective, concurrent, and/or retrospective basis (prepayment or postpayment) the Medical Necessity of Covered Services furnished to Members, as more fully set forth in the Policies.

SECTION II General Terms and Conditions

2.1 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.

2.2 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 thirty (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

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2.3. 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

2.4. Each party represents and covenants that it has, and shall maintain, a currently valid, unrestricted and unconditional license, certification and/or approvals necessary to provide or cause the provision of the Services in accordance with the terms and conditions of this AGREEMENT and it will ensure that all services provided hereunder are provided in accordance with all applicable federal, state and local laws, regulations and agency guidelines

2.5. 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.

2.6. The Provider or IPA agrees , pursuant to 31 U.S.C.§1352 and CFR Part 93, that no Federally appropriated funds have been paid or will be paid to any person by or on behalf of the Provider/IPA for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of any Federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement. The Provider or IPA agrees to complete and submit the "Certification Regarding Lobbying", Attachment C, attached hereto and incorporated herein, if this Agreement exceeds $100,000. If any funds other than Federally appropriated funds have been paid or will be paid to any person for the purpose of

influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of a member of Congress, in connection with the award of any Federal Contract, the making of any Federal grant, the making of any Federal loan, the entering of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement, and the Agreement exceeds $100,000 the Provider or IPA shall complete and submit Standard Form-LLL "Disclosure Form to Report Lobbying," in accordance with its instructions.

SECTION III Obligations of LHSCA

3.1 Provision of Services.

LHSCA will provide Covered Services to Members according to (i) the Member's Plan of Care, (ii) generally accepted standards of health care practice in LHSCA's community, (iii) accepted medical ethics, (iv) the scope of LHSCA's licensure, certification, or accreditation, (v) the applicable Benefit Plan, and (vi) the terms and conditions of this Agreement. LHSCA will render services to Members in a manner that assures continuity of care including, but not limited to, forwarding all pertinent information relating to the health care of Members to Members' primary care Provider and, as required, to MCO in a timely fashion. LHSCA shall arrange for and provide such Home Health Care Services on a timely basis, as requested and in accordance with any schedule provided by LHSCA

LHSCA agrees to immediately notify ACM IPA of any adverse member visit encounters, incidents and/or complaints related to, arising from or otherwise affecting its provision of services to MCO members .

a. LHSCA shall comply with all the requirements of the mandatory statewide Criminal History Record Checks (CHRC) program enacted by New York State effective April 1, 2005. LHSCA shall furnish only those aides for whom LHSCA has undertaken CHRC's by obtaining aides' fingerprints and submitting same to the New York State Department of Health in compliance with all CHRC requirements, and whose employment by LHSCA is otherwise in full compliance with CHRC requirements.

b. LHSCA agrees that all personnel who provide plan of care services have complete and current personnel records on file with LHSCA in compliance with all laws, regulations and rules, including, without limitation, 10 NYCRR Part 766, and in accordance with the requirements of the Form I-9 of the Federal Immigration and Naturalization Service.

c. LHSCA shall maintain appropriate levels of professional and general liability insurance to cover their provision of services hereunder.

d. Notwithstanding any other provision in this Agreement, LHSCA agrees that it will (a) ensure that any service provided pursuant to this Agreement complies

with all pertinent provisions of federal, state and local statutes, rules and regulations; (b) plan, coordinate and ensure the quality of services provided; and (c) ensure adherence to the plan of care established for patients.

e. IPA and/or MCO will have the exclusive right, at any time, to refuse the assignment of any aide provided by the LHSCA, and to shorten, terminate, lengthen, or change the assignment of the aide, and shall notify the LHSCA of any such action.

3.2 **Patient Confidentiality**

Each party agrees to abide by Health Information Technology for Economic and Clinical Health Act, Title XIII of the American Recovery and Reinvestment Act of 2009 and regulations promulgated thereunder ("HITECH") and the Health Insurance Portability and Accountability Act of 1996 and any regulations promulgated thereunder ("HIPAA"). In addition, each party agrees to be bound by all other federal, state and local rules and regulations that require the patient information be kept confidential, private and secure.

3.3 **Non-Discrimination** 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. The parties to this Agreement agree to comply with all applicable requirements of the Federal Americans with Disabilities Act.

3.4 **Legal and Regulatory Compliance**. LHSCA will comply with all State and Federal laws, regulations, rules, ACM IPA Contract provisions, Payor provisions, MCO Contract provisions, interpretations and instructions issued by ACM IPA, MCO, or regulators specifically relating to the delivery of Covered Services and the conduct of LHSCA operations. Such requirements include, but are not limited to, the provisions of any Attachments hereto that are specific to a particular Payor. LHSCA acknowledges that MCO oversees, and is accountable to Payors, for any functions and responsibilities set forth in the Payor Contracts or applicable law.

3.5 **Compliance with Policies.** The MCO and the IPA agree and shall require the LHSCA to comply fully and abide by the rules, policies and procedures that the MCO and IPA (a) has established or will establish to meet general or specific obligations placed on them by statute, regulation, or DOH or SID guidelines or policies and (b) has provided to the LHSCA at least thirty (30) days in advance of implementation, including such Policies will require LHSCA to cooperate with IPA and MCO, participate in, and be bound by the applicable rules, policies, procedures and programs of these organizations including with regard to, but not limited to:

☐ Utilization management and Utilization Review (including preauthorization, referral processes and pre-certification procedures, concurrent and retrospective (pre-payment and post-payment) review);

☐ Care management;

☐ Quality Assurance and Improvement (including any applicable plan of correction);

☐ Member grievances and appeals;

☐ External review programs;

☐ Encounter data reporting;

☐ Performance improvement and Member satisfaction surveys;

☐ Outcome measurements;

☐ Credentialing;

☐ Compliance and Fraud, Waste and Abuse detection and prevention;

☐ Notice of Non Coverage and PRO Reviews; and

☐ HEDIS and QARR reporting requirements.

Any reference to IPA quality assurance (QA) activities within this Agreement is limited to the IPA's and/or MCOs analysis of utilization patterns and quality of care as a requirement for Federal or State healthcare regulating bodies and for quality improvement functions to its contracted MCOs and providers. Additionally, LHSCA will comply with ACM IPA and MCO Quality Improvement and Utilization Management activities. Such activities include the requirement that LHSCA: (i) follow the plan of care and undergo concurrent review to ensure the provision of services under the IPA and MCO Utilization Management programs, including, but not limited to the concurrent review of services, (ii) cooperate with Claims payment review; (iii) cooperate with Member grievances; (iv) cooperate with Provider credentialing; (v) follow guidelines related to electronic submission of Claims and other data; (vi) follow any applicable participation criteria required by DOH in connection with the provision of services under a government program; and (vii) work in good faith to implement corrective action(s) initiated by the IPA and MCO Quality Improvement programs in order to improve the service delivered to Members. IPA or MCO will inform LHSCA at least thirty (30) days prior to any material modification of the Policies, via posting to applicable websites or other means. The Policies and any modifications thereto are hereby incorporated by reference

3.6. **Compliance with Wage ParityLaw**

ACM IPA must obtain the completed certification (Attachment B) that attests that the contracted LHSCA is in compliance with this provision. These certifications must include all information necessary to verify compliance and that such information will be submitted to ACM IPA at least quarterly by the contracted LHSCA. Failure to fully

comply with the terms of the Home Care Worker Parity requirements will result in non-payment of services rendered. All providers must maintain records of compliance for at least 10 years and such records are to be made available to the Department upon request

LHSCA must certify a full compliance with the terms of NYS Public Health Law 3614c, the Home Care Worker Wage Parity Law as it is outlined below

- 3/1/2012 - 2/28/2013:

  90% of the total compensation mandated by the living wage law of NYC

- 3/1/2013 - 2/28/2014:

  95% of the total compensation mandated by the living wage law of NYC

- 3/1/2014 and beyond the following applies:

No less than the prevailing rate of total compensation as of 1/1/2011 or the total compensation mandated by the living wage law, whichever is greater.

3.7. **Excluded LHSCA Compliance**

Each party represents, warrants and covenants to other party that, during the term of the Agreement, it and each of its employees, contractors and/or agents has not been convicted of a criminal offense that falls within the ambit of 42 USC 1320a-7(a), or is excluded, debarred, suspended or otherwise ineligible to participate in the Federal health care programs or in Federal procurement or non-procurement programs. Without limiting the foregoing, each party agrees to use its reasonable efforts to check, before hiring staff and every thirty (30) days thereafter, all of its all employees, contractors and/or agents whose salaries are directly or indirectly paid for by a federal health care program against the exclusion lists maintained by the following:

- US Department of Health and Human Services' Office of Inspector General;
- General Services Administration;
- New York State Office of Medicaid Inspector General (each individual or entity appearing on one or more of these lists is referred to as an "Ineligible Person."). LHSCA shall maintain proof of such monthly checks for at least ten years that shall be made available to ACM IPA promptly upon its request.

Each party shall immediately notify the other party in writing in the event any of its employees, contractors or agents appear on one or more of these lists and shall immediately remove an Ineligible Person from providing services to or on behalf of the other party. Such sanction may require the party to terminate the employment or agreement with such Ineligible Person. Notice of Ineligible Persons should be directed to ACM IPA. If the LHSCA becomes an Ineligible Person or has a pattern of employing, contracting or using agents who become Ineligible Persons, ACM IPA shall have the right to immediately terminate this AGREEMENT.

4. Access to Books and Records.

As and if required by 42 U.S.C. Section 1395x (v)(1)(l) and any regulations promulgated thereunder, the LHSCA shall, upon written request, make available, until the expiration of four years from the termination of this Agreement, to the Secretary of Health and Human Services of the United States and to the Comptroller General of the United States, or to any of their duly authorized representatives, this Agreement and any books, documents, and records of the LHSCA that are necessary to certify the nature and extent of the LHSCA's costs under this Agreement.

5. Non Compete

For the period of this agreement and for a one year term following the expiration or termination of this agreement, LHSCA agrees that it will not pursue or enter into any direct relationship to provide comparable services as described herein, with any MCO and MLTC programs that are contracted with ACM IPA, unless the continuation of services is mandated by the DOH.

6. Independent Contractor Status

Any aide furnished pursuant to this AGREEMENT shall not be, nor shall be considered to be, an employee of ACM IPA or MCO. The aides shall be deemed employees of the LHSCA, and the LHSCA shall have the direct responsibility for payment of wages and other compensation, reimbursement of expenses, and compliance with federal, state and local tax requirements pertaining to withholding, Workers' Compensation, Social Security, unemployment and other insurance requirements and obligations imposed on the employer of personnel with regard to the aides. Except as may otherwise be expressly contained herein, neither the LHSCA nor any of its aides shall have any right or authority to assume or create any obligation or responsibility on behalf of, or in the name of ACM IPA or MCO or to bind either in any manner whatsoever, nor shall ACM IPA or MCO have any obligation or responsibility for any expenses or liabilities which may be incurred by or imposed upon any such persons.

7. Claim Submittal and Payment

ACM IPA or MCO agree to compensate LHSCA for paraprofessional services at the agreed upon rate and by the agreed upon entity as indicated on ATTACHMENT A COMPENSATION for all patients that are provided LHSCA services according to the "Plan of Care" The LHSCA shall be responsible for providing to ACM IPA via electronic means all hours and/or visits provided by LHSCA to MCO patients. LHSCA shall also provide valid documentation of these hours and/or visits, as well as the tasks performed by the assigned aide either through the maintenance of duty sheets or through "call- in" system records, which shall be available to ACM IPA or MCO upon request.

The LHSCA shall ensure the following:

- ninety percent (90%) of the hours of service provided shall be entered and be submitted to ACM IPA within thirty (30) days from the last date of service for the weeks

being submitted (e.g., records for the week ending on or about the 1st. of the month must be submitted by the end of the month);

- ninety-nine percent (100%) of the hours of service provided shall be entered and be available to ACM IPA or MCO within forty five (45) days from the last date of service for the week being submitted; and
- Alliance IPA may pay claims denied for untimely filing where the provider can demonstrate that a claim submitted after 45 days of the date of service resulted from an unusual occurrence and the provider has a pattern of timely claims submissions.
- Claims submitted beyond 45 days will be paid at a 25% discount.

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

8 Arbitration

This Agreement shall be governed in all respects by the laws of the applicable New York State and federal laws, regulations or rules. 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.

9. Term

This AGREEMENT begins on _____ and continues for the period of three years and will be automatically renewed, unless terminated by either party made in writing to the other party giving 30 day notice or terminated immediately for cause as described herein

By executing this AGREEMENT through the signature below, the initialing of Attachment A Compensation and the completion and signing of Attachment B and C, the LHSCA acknowledges receipt of and agreement with each individual Section of this Agreement together with the Attachments and with the accurately completed Credentialing Application, taken as a whole and duly executed below

ALLIANCE CARE MANAGEMENT IPA On behalf of **LHSCA:**

By:_____ By:_____

Printed Name:_____ Printed Name _____

Title: _____ Title: _____

Date: _____ Date: _____

ATTACHMENT A

COMPENSATION

The LHSCA is compensated by ACM IPA according to this Attachment A for the provision of Home Health Care services by Home Health Aids and Personal Care Aids qualified under the terms of this agreement and according to the MCO member's Plan of Care

THE Parties agree that the compensation for services are indicated below and accepted by the duly executed signature page of this agreement

(to be negotiated)

Initialed_____

Initialed_____

Attachment B
Wage Parity

Certification of Compliance with Home Care Worker Wage Parity

I hereby certify that all services provided by _____ for the period March 1, 2012 and subsequent are in full compliance with the Home Care Worker Wage Parity terms of section 3614-c of the Public Health Law and any regulations promulgated pursuant to this provision of Law. I further certify that I will maintain all records necessary to verify compliance with the terms of this section (including required licensed home care service agency attestations and information) for a period of no less than ten (10) years from the end of the applicable calendar year; and that such records will be subject to audit by VNSNY, the Department and/or its agents for possible retroactive recoupment of payments for services that are determined to be in less than full compliance.

Name of Contractor _____
Operating Cert No _____
Signature _____

Does organization currently have a collective bargaining agreement (CBA) that covers home care aides?

Please indicate Yes or No No yes, attach the names of the entities the CBAs are with.

Name (Please Print) _____

Title (Please Print) _____

Please note that only the following individuals may sign the attestation form:
Proprietary Sponsorship – Operator/ Owner
Voluntary Sponsorship – Officer (President, Vice President Secretary or Treasurer), Chief Executive officer, Chief Financial Officer or Chairperson
Public Sponsorship – Public Official Responsible for the Operation of the Facility

Attachment C
CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge, that:

1. No Federal appropriated funds have been paid or will be paid to any person by or on behalf of the Provider for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of a Member of Congress in connection with the award of any Federal loan, the entering into any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress in connection with the award of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into any cooperative agreement, or the extension, continuation, renewal, amendment or modification of this Federal contract, grant, loan, or cooperative agreement, and the Agreement exceeds $100,000, the Provider shall complete and submit Standard Form-LLL "Disclosure Form to Reporting Lobby," in accordance with its instructions.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into submission of this certification is a prerequisite for making or entering into this transaction pursuant to U.S.C. Section 1352. The failure to file the required certification shall subject the violator to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

DATE: _____

TITLE: _____

ORGANIZATION: _____

NAME: (Please Print) _____

SIGNATURE: _____

Standard Clauses

The “New York State Department of Health Standard Clauses for Managed Care Provider/IPA Contracts," attached to this Agreement as Attachment 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 attachments, appendices, amendments and exhibits, the parties agree that the provisions of the Standard Clauses shall prevail, except to the extent applicable law requires otherwise and/or to the extent a provision of this Agreement exceeds the minimum requirements of the Standard Clauses.

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.

A. Definitions For Purposes Of This Appendix

"Managed Care Organization " or "MCO " shall mean the person, natural or corporate, or any groups of such persons, certified under Public Health Law Article 44, who enter into an arrangement, agreement or plan or any combination of arrangements or plans which provide or offer, 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 physicians, dentists, nurses, pharmacists and other health care professionals, pharmacies, hospitals and other entities engaged in the delivery of health care services which are licensed, registered and/or certified as required by applicable federal and state law.

B. General Terms And Conditions

1. This Agreement is subject to the approval of the New York State Department of Health 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.

2. 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 thirty (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.

3. 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.

4. 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:

o quality improvement/management

o utilization management, including but not limited to precertification procedures, referral process or protocols, and reporting of clinical encounter data

o member grievances; and

o provider credentialing

5. 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.

6. If the Provider is a primary care practitioner, 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.

7. 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.

8. Notwithstanding any other provision of this Agreement, the parties shall comply with the provisions of the Managed Care Reform Act of 1996 (Chapter 705 of the Laws

of 1996) Chapter 551 of the Laws of 2006, Chapter 451 of the Laws of 2007 and Chapter 237 of the Laws of 2009 with all amendments thereto.

9. 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.

f. The Provider or IPA agrees to provide medical records to the MCO for purposes of determining newborn eligibility for Supplemental Security Income where the mother is a member of the MCO and for quality purposes at no cost to the MCO.

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

influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of a member of Congress, in connection with the award of any Federal Contract, the making of any Federal grant, the making of any Federal loan, the entering of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement, and the Agreement exceeds $100,000 the Provider or IPA shall complete and submit Standard Form-LLL "Disclosure Form to Report Lobbying," in accordance with its instructions.

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

i. The Provider agrees to monitor its employees and staff against the List of Excluded Individuals and Entities (LEIE) and excluded individuals posted by the OMIG on its Website.

j. The Provider agrees to disclose to MCO complete ownership, control, and relationship information.

k. Provider agrees to obtain for MCO ownership information from any subcontractor with whom the provider has had a business transaction totaling more than $25,000, during the 12 month period ending on the date of the request made by SDOH, OMIG or DHHS. The information requested shall be provided to MCO within 35 days of such request.

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

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

C. Payment; Risk Arrangements

1. 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 copayments, coinsurance amounts, or permitted deductibles, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to a covered person provided that Provider shall have advised the enrollee in writing that the service is uncovered and of the enrollee's liability therefore prior to providing the service. Where the Provider has not been given a list of services covered by the MCO, and/or Provider is uncertain as to whether a service is covered, the Provider shall make reasonable efforts to contact the MCO and obtain a coverage determination prior to advising an enrollee as to coverage and liability for payment and prior to providing the service. This provision shall survive termination of this Agreement for any reason, and shall supersede any oral or written agreement now existing or hereafter entered into between Provider and enrollee or person acting on his or her behalf.

2. Coordination of Benefits (COB). To the extent otherwise permitted in this Agreement, the Provider may participate in collection of COB on behalf of the MCO, with COB collectibles accruing to the MCO or to the provider. However, with respect to enrollees eligible for medical assistance, or participating in Child Health Plus 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.

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

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

5. The parties agree that a claim for home health care services following an inpatient hospital stay cannot be denied on the basis of medical necessity or a lack of

prior authorization while a utilization review determination is pending if all necessary information was provided before a member's inpatient hospital discharge, consistent with Public Health Law §4903.

D. Records; Access

1. Pursuant to appropriate consent/authorization by the enrollee, the Provider will make the enrollee's medical records and other personally identifiable information (including encounter data for government-sponsored programs) available to the MCO (and IPA if applicable), for purposes including preauthorization, concurrent review, quality assurance, (including Quality Assurance Reporting Requirements (QARR)), payment processing, and qualification for government programs, including but not limited to newborn eligibility for Supplemental Security Income (SSI) and for MCO/Manager analysis and recovery of overpayments due to fraud and abuse. The Provider will also make enrollee 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.

2. 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 Office of the Medicaid Inspector General, the New York State Attorney General, and the Comptroller General of the United States and their authorized representatives upon request. This provision shall survive the termination of this Agreement regardless of the reason.

3. The parties agree that medical records shall be retained for a period of six (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.

4. The MCO and the Provider agree that the MCO will obtain consent directly from enrollees at the time of enrollment or at the earliest opportunity, or that the Provider will obtain consent from enrollees at the time 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 consent for disclosure of medical records.

E. Termination and Transition

1. 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.

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

3. If this Agreement is between an MCO and an IPA, 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.

4. 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.

5. 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.

6. 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.

F. Arbitration

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

G. IPA-Specific Provisions

1. 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.