Warren County Health Services
Health Services Committee Meeting
April 26, 2013
Information Submitted By: Patricia Auer, DPH/DPS

Action Agenda/New Business

Request Resolution:
To amend the agreement with Preferred Medical Claims Solutions LLC to allow for an increase in reimbursement for services.
Rationale:
The reimbursement with this agreement will now cover 92% of our total costs, which is quite satisfactory in light of the fact many payers are not this high. We would also request that we be authorized upon review by the County Attorney to negotiate and accept increased reimbursements without the need to return to committee. We already have a number of insurances where this is the case. It allows for reimbursements to be actualized faster.

Request Resolution:
To amend the contract with Aetna Health Inc. to allow for the receipt of increased rates for various services, and to further authorize the receipt of increased rated for services as they are negotiated by the Health Services Department without further need of resolution as long as the changes are approved by the County Attorney.
Rationale:
This will allow for more expeditious receipt of increased rates when they are offered.

Request Resolution:
To authorize the Health Services Department to participate in the Americares US Partnerships program to allow for receipt of specific vaccines offered. An administration fee would be charged to the individual patients, but no charge for the vaccine. This would allow individuals not covered by insurances to receive vaccines with only an administration fee.
Rationale:
There is no cost to the county for this program. There is no "contract" to sign in the usual sense. The program is done totally online, where we need to "check the boxes" that we will not charge for the vaccine, that we are a local health department and that we have a medical director with appropriate credentials.

Request Referral to Personnel Committee:
For authorization to back fill a. Public Health Nursing position Grade 21, base salary $43,905.
Rationale:
The vacancy is created by a resignation. The employee was still in the probationary period, and was a good nurse, but family issues prevented her from continuing with us. She will remain on a per diem basis as her situation allows.

Request Resolution:
To allow Sharon Schaldone, ADPH and Tammie DeLorenzo, Clinical and Fiscal Informatics Coordinator to attend the Delta Health Technologies 2013 National Customer Forum in Altoona, Pennsylvania from June 24 – 27, 2013 at a total cost for the conference and lodging of $1.095, plus the GSA rates not to exceed $77.00 per day for incidental expenses and $46.00 per day for food paid upon submission of appropriate receipts.
Rationale:
This conference, although pricy, is important to attend in that there is a new feature to the Delta Health Care System (our Electronic Medical Record System) that will discussed, along with other situations regarding the system that it are important. Tammie DeLorenzo is the President of the Users Group, and because it is important she be present she will ask if some assistance with the conference fee would be possible. It may not be, but it doesn't hurt to ask. We will save $50.00 per person on the conference fee at the "Early Bird Rate" if the registration is received by May 15. This rate was calculated with the above stated amounts. The employees will drive to Altoona in a Health Services Fleet vehicle, and both Sharon and Tammie will be present at the meeting to answer any questions the committee may have. We have funds in the 2013 Budget to cover the expense.

Request Resolution:
To authorize Cathy DuFour, PHN to attend the Home Care Association of New York State ICD-9-CM and Oasis Coding Workshop and take the Coding Recertification Exam at the Hilton Garden Inn in Newburgh, New York on September 16 -18 at a cost of $399.00 for the Workshop, $189.00 for the Recertification Exam, $278.00 for lodging and reimbursement at the GSA rates for food and incidental expenses paid upon submission of appropriate receipts.
Rationale:
This employee is our only Certified Coder, and the recertification test must be taken every two years. It is imperative that we have a certified coder as the correct coding allows the agency to receive maximum reimbursement for services. Newburgh is the area where the workshop and test are being given this year. A Health Services Fleet vehicle will be used for travel. There are funds in the 2013 Budget to cover the cost.

Pending Items

Update on the Certificate of Need Process for Certified Home Health Agencies:
There continues to be no new information to report.

Update on Supervising Public Health Nurse Position:
We have interviewed 4 qualified candidates who expressed interest and submitted resumes. We have selected one of the nurses and will request approving the salary at the May Personnel Committee so we will be on track for the employee to begin when the retiring supervisor leaves at the end of May.

Items for Discussion/Information

Emergency Response and Preparedness Activities
Please see **Attachment #1** for the monthly report.

Report of Expenditures, Revenues, Overtime and Per Diem Use
Please see **Attachment #2.**
Tawn Driscoll, Fiscal Manager, will be present at the meeting to answer any questions.

Attachments:
#1 Emergency Response and Preparedness Activities Report
#2 Reports of Expenditures, Revenues, Overtime and Per Diem Use

BT ACTIVITY SHEET
BP1 - 7/1/12 - 6/30/13
Page 1
Topic Color Codes
Red/Chempack; Green/SNS; Blue/Mass Fatality; Black/Training; Purple/Special Needs; Orange/Drill; Black/Pan Flu

Attachment 1

Date	Type	Subject/Comments	Attendees	Topic (i.e. Chempa Drill, Mass Fatality, SI Training, Pan Flu, Spe Needs)
4/2013	Updates	to all plans for grant deliverables due 4/15/13	Dan Durkee, Angela Meade, Laura Saffer, Ginelle Jones, Amy Drexel	
4/3/12	Meeting	L-3 Capital District sub-regional planning group of the Health Emergency Preparedness Coalition (HEPC) at HANYs	Dan Durkee	
4/9/13	Program	Handwashing & Peach Tree Day Care	Laura Saffer	
4/9/13	Meeting	BT Coordinators (Ballston Spa)	Dan Durkee	
4/11/13	Student – Sage	EPR	Laura Saffer	
4/11/13	Meeting	Washington County BT	Laura Saffer	
4/15/13	Meeting	M-12 GFH bomb scenario functional drill at Queensbury Elementary School	Dan Durkee	
4/21/13	Full Scale Exercise	M-12 GFH bomb scenario functional drill at Queensbury Elementary School	Dan Durkee, Laura Saffer	Drill
4/24/13	Meeting	Quarterly EPR Committee	Dan Durkee, et.al	
4/24/13	Webinar	ClinOps	Laura Saffer, Angela Meade	
4/25/13	Student – Sage	EPR	Laura Saffer	

WARREN COUNTY HEALTH SERVICES BUDGET ANALYSIS

REVENUE AND EXPENDITURES FOR 2013 AS OF 4/24/2013 4:14:54 PM

FUND(S): A, CL, D, DM, EF, GI, MS, SD, V

CODE(S): 4010, 4011, 4013, 4016, 4018, 4046, 4054, 4189, 4025

EXPENSES	2013 BUDGETED	2013 YTD ACTUAL	2012 Prior Year Totals
Salaries - Regular	$2,854,176.00	$856,918.20	$2,792,734.39
Salaries - Overtime	$137,500.00	$52,675.47	$134,883.37
Salaries - Part Time	$279,557.00	$67,048.57	$219,854.62
Salaries - Sick Leave Incentive			$800.00
100's PERSONAL SERVICES	$3,271,233.00	$976,642.24	$3,148,272.38
200's EQUIPMENT	$104,429.90	$11,429.06	$180,916.48
400's CONTRACTUAL	$8,394,117.50	$1,101,565.32	$6,668,622.53
800's EMPLOYEE BENEFITS	$1,790,236.00	$577,342.51	$1,613,292.82
TOTALS	$13,560,016.40	$2,666,979.13	$11,611,104.21

REVENUES	2013 BUDGETED	2013 YTD ACTUAL	2012 Prior Year Totals
	$11,107,737.00	$1,006,494.90	$9,558,965.60

Notes: Revenue of $320,791.74 has been accrued for February billing for CHHA, MCH and LTC Programs. We are currently working on closing March billing. Also, $12,172.23 has been accrued for the CSHCN Grant $4,300, Rabies Grant $420.23, and EI Grant of $7,452.

Also, for 2012 $33,166.84 in revenue was accrued, OHS grant $14,250 and Preschool Evals for 12/13 SY $18,916.84. While 2012 has not been officially closed, all our Preschool revenue all our Preschool revenue and WIC program food vouchers have been noted in totals above.
At this time, it appears that Health Services for 2012 bottom line impact to the county will be approximatelv $427,128.57 less than budgeted, therefore a positive impact to the county.

Warren County Health Services

Salaries Comparison

2012 vs 2013

as of 4/21/13 Payroll date ending

Total of All Depts	YTD 2013	YTD 2012	YTD 13v12	% Change	Total Budget 2013	Total Actual 2012
Regular Salaries	$856,918.20	$866,658.54	-$9,740.34	-1.12%	$2,854,176.00	$2,792,734.39
Overtime Salaries	$52,675.47	$41,023.68	$11,651.79	28.40%	$137,500.00	$134,883.37
Part Time Salaries	$67,048.57	$67,509.27	-$460.70	-0.68%	$279,557.00	$219,854.62
Sick Leave Incentive	$0.00	$0.00	$0.00	0.00%	$0.00	$800.00
TOTALS	$976,642.24	$975,191.49	$1,450.75	0.15%	$3,271,233.00	$3,148,272.38

*Source: Detail G/L report for all Salary Category from 1/1/XX-4/21/XX

Note: Regular salaries are below last year due to nursing positions that were open and the time difference throughout year to fill those positions, however, overtime salaries for 2013 YTD are above 2012 YTD since coverage was needed for patients due to these staffing shortages. Now that most positions have been filled, we should see less overtime in the near future.
Also in 2013, all union members got increases which are reflected above.
Part time salaries are slightly below last year primarily due to the reduction in Part time salaries for the disease program in which many clinics have been eliminated or reduced.

RESOLUTION REQUEST FORM NO. 4

Request for Extending, Rescinding or Amending Resolution

DEPARTMENT NAME: Health Services

DATE: 04/26/13

(a) Purpose of Contract Change: To amend the agreement with Preferred Medical Claims Solutions LLC to allow for increased payment of services.

(b) Resolution Number, or Numbers if Amended, which Authorized the Original Contract: see attached agreement of 2004 – no resolution found.

(c) Name of Contractor: Preferred Medical Claims Solutions LLC

(d) Address of Contractor: 9060 East Via Linda Suite 250
Scottsdale, Arizona 85258

(e) Contractor's Contact Person and Telephone Number: Carrie Nash
Provider Services Director 877-768-1968 ext. 234, fax 866-366-7596
Email: cnash@pmcsonline.com

(f) Commencement Date of Amendment: 05/20/13

(g) Termination Date of Extension: per terms specified in agreement

(h) Payment Provisions: per terms specified in the attached agreement

i) lump sum amount
ii) hourly rate amount
iii) total amount not to exceed
iv) how will payments be made (i.e. monthly, quarterly, upon completion of the project, etc.

(i) Where are the Funds for this Contract ? List Budget Code, (with title), Object Code (with title), and Amount **OR** Capital Project **OR** Capital Reserve Project Number and Title and Amount:
A.4010.1610 Home Health Agency CHHA Revenue
A.4018.003.1613 Disease Program Immunization Revenue

PMCS
Preferred Medical Claim Solutions

Date:	April 15, 2013	**Payment Remittance Address:**		**Attn:**	Pat Auer
Provider:	**Warren County Health Services**	1340 State Rte 9		**TIN #:**	**14-6002576**
Phone #:	**(518) 761-6418**	Lake George, NY 12845		**Fax #:**	**(518) 761-6418**

This agreement is between Preferred Medical Claim Solutions LLC ("PMCS") and the Provider tax identification number (TIN) listed above and becomes effective upon execution by the parties. This agreement will replace the previous agreement which was executed on 5/18/2004. Further, this agreement will encompass all services provided by Warren County Health Services under said TIN.

This Agreement shall continue in effect for a period of one (1) year from the date of execution and will automatically renew successive one (1) year terms. Either party may terminate this agreement without cause by providing thirty (30) days written notice to the other party.

PMCS and Provider enter into this agreement under the following terms and conditions:

1) You agree to accept 92% of the Total Billed Charges as the Adjusted Amount on all claims processed by PMCS. Claims sent to PMCS with reasonable and customary reductions may not be processed under this agreement.

2) You hereby assign to PMCS or its assigns all sums due on all claims advance funded by PMCS without offset and authorize PMCS to deposit checks or instruments received in payment of those claims.

3) You agree not to balance bill the payor, administrator, and/or patient for the difference between the Total Billed Charges and the Adjusted Amount in accordance with the terms of the agreement.

4) In consideration, PMCS promises you will receive payment of Adjusted Amount, less patient co-pay, deductible, co-insurance and non-covered amounts within 15 working days from the date the claim is received by PMCS.

5) You agree that if payments due to PMCS under this Agreement are inadvertently forwarded to You by payor, such payment will be sent to PMCS.

6) If for any reason any claim is deemed ineligible or benefits were improperly determined, upon written notice, you agree that any payments made by PMCS under this agreement for any claim will be reimbursed to PMCS.

Please sign below and fax to 866-784-4504 or call us at 877-768-1968.

Upon receipt of this Agreement by the parties, all open and future claims will be processed in accordance with this Agreement and payment, along with an Explanation of Payment (E.O.P.), will be forwarded to your patient accounts department at the address shown on the claim.

I have the authority to accept the provisions outlined in this agreement; and further provide PMCS the assurance that proceeds associated with these claims have not been previously assigned to any other individual or organization.

Initial if Payment address is correct above	Signature	Date
	Printed Name / Title	E-Mail

Thank you for your time and consideration. We look forward to working with you in the near future.

Sincerely,

Carrie Nash
Provider Services Director

9060 East Via Linda * Suite 250 * Scottsdale * Arizona 85258
Telephone 877.768.1968 Fax 877.768.1969
www.pmcsonline.com

PMCS
Preferred Medical Claim Solutions

Date:	April 15, 2013	**Payment Remittance Address:**		**Attn:**	Pat Auer
Provider:	**Warren County Health Services**	1340 State Rte 9		**TIN #:**	**14-6002576**
Phone #:	**(518) 761-6418**	Lake George, NY 12845		**Fax #:**	**(518) 761-6418**

This agreement is between Preferred Medical Claim Solutions LLC ("PMCS") and the Provider tax identification number (TIN) listed above and becomes effective upon execution by the parties. This agreement will replace the previous agreement which was executed on 5/18/2004. Further, this agreement will encompass all services provided by Warren County Health Services under said TIN.

This Agreement shall continue in effect for a period of one (1) year from the date of execution and will automatically renew successive one (1) year terms. Either party may terminate this agreement without cause by providing thirty (30) days written notice to the other party.

PMCS and Provider enter into this agreement under the following terms and conditions:

1) You agree to accept 92% of the Total Billed Charges as the Adjusted Amount on all claims processed by PMCS. Claims sent to PMCS with reasonable and customary reductions may not be processed under this agreement.

2) You hereby assign to PMCS or its assigns all sums due on all claims advance funded by PMCS without offset and authorize PMCS to deposit checks or instruments received in payment of those claims.

3) You agree not to balance bill the payor, administrator, and/or patient for the difference between the Total Billed Charges and the Adjusted Amount in accordance with the terms of the agreement.

4) In consideration, PMCS promises you will receive payment of Adjusted Amount, less patient co-pay, deductible, co-insurance and non-covered amounts within 15 working days from the date the claim is received by PMCS.

5) You agree that if payments due to PMCS under this Agreement are inadvertently forwarded to You by payor, such payment will be sent to PMCS.

6) If for any reason any claim is deemed ineligible or benefits were improperly determined, upon written notice, you agree that any payments made by PMCS under this agreement for any claim will be reimbursed to PMCS.

Please sign below and fax to 866-784-4504 or call us at 877-768-1968.

Upon receipt of this Agreement by the parties, all open and future claims will be processed in accordance with this Agreement and payment, along with an Explanation of Payment (E.O.P.), will be forwarded to your patient accounts department at the address shown on the claim.

I have the authority to accept the provisions outlined in this agreement; and further provide PMCS the assurance that proceeds associated with these claims have not been previously assigned to any other individual or organization.

Initial if Payment address is correct above	Signature	Date
	Printed Name / Title	E-Mail

Thank you for your time and consideration. We look forward to working with you in the near future.

Sincerely,

Carrie Nash
Provider Services Director

05-20-'04 15:27 FROM-
05-17-'04 11:41 FROM-

T-179 P20/29 U-549

Preferred Medical Claim Solutions LLC

Date:	May 17, 2004	Attn:	BILLING
Provider:	WARREN COUNTY HEALTH SERV	TIN #:	14-6002576
Phone #:	518-761-6415	Fax #:	(518) 761-6562

This agreement is between Preferred Medical Claim Solutions LLC ("PMCS") and the Provider TIN listed above and becomes effective upon execution by the parties.

This Agreement shall continue in effect for a period of one (1) year from the date of execution and will automatically renew successive one (1) year terms. Either party may terminate this agreement without cause by providing thirty (30) days written notice to the other party.

PMCS and Provider enter into this agreement under the following terms and conditions:

1) You agree to accept 65% of the Current Billed Charges as the Adjusted Billed Charges on all claims processed by PMCS.

2) In consideration, You will receive payment of Adjusted Billed Charges, less patient co-pay, co-insurance and deductible amounts within 12-15 working days from the date the claim is received by PMCS.

3) You agree not to balance bill the payor, administrator, and/or patient for the difference between the Current Billed Charges and the Adjusted Billed Charges in accordance with the terms of the agreement.

4) You assign to PMCS or its assigns all sums due on all claims processed by PMCS and authorizes PMCS to deposit checks or instruments received in payment of those claims.

5) You agree that if payments due to PMCS under this Agreement are inadvertently forwarded to You by payor, such payment will immediately be sent to PMCS.

6) If for any reason any claim is deemed ineligible or benefits were improperly determined, upon written notice, you agree that any payments made by PMCS under this agreement for any claim will be immediately reimbursed to PMCS.

Please sign below and fax to (973) 218-0052 or call us at (888) 466-0068 ext. 237.

Upon receipt of this Agreement by the parties, all open and future claims will be processed in accordance with this Agreement and payment, along with an Explanation of Payment (E.O.P.), will be forwarded to your patient accounts department at the address shown on the claim.

I have the authority to accept the provisions outlined in this agreement; and further provide PMCS the assurance that proceeds associated with this claim have not been previously assigned to any other individual or organization.

Sharon Schaldone — Signature — 5/18/04 — Date

Sharon Schaldone — Printed Name — Schaldone@co.Warren.ny.us — E-Mail

Thank you for your time and consideration. We look forward to working with you in the near future.

Sincerely,

Paula Roberti
National Claims Manager

#157867

60 Morris Turnpike • 3rd Floor • Summit • New Jersey 07901
Telephone 973.218.0007 FAX 973.218.0052

RESOLUTION REQUEST FORM NO. 4

Request for Extending, Rescinding or Amending Resolution

DEPARTMENT NAME: Health Services

DATE: 04/26/13

(a) Purpose of Contract Change: To amend the contract with Aetna Health Inc. to allow for the receipt of increased rates for various services and to further authorize the receipt of increased rates for services as they are negotiated by the Health Services Department without further need of BOS resolution in a form approved by the county attorney.

(b) Resolution Number, or Numbers if Amended, which Authorized the Original Contract: R 504/2003 (see attached)

(c) Name of Contractor: Aetna

(d) Address of Contractor: Contract Consulting Unit
151 Farmington Avenue R52A
Hartford, CT 06156

(e) Contractor's Contact Person and Telephone Number: Lee Sandell Network Account Manager, National Ancillary Contracting, Sandell@aetna.com, 888-632-3862.

(f) Commencement Date of Amendment: 06/01/13

(g) Termination Date of Extension: per terms of agreement (see attached contract) p. 15 of 38

(h) Payment Provisions: per terms of attached agreement

i) lump sum amount
ii) hourly rate amount
iii) total amount not to exceed
iv) how will payments be made (i.e. monthly, quarterly, upon completion of the project, etc.

(i) Where are the Funds for this Contract ? List Budget Code, (with title), Object Code (with title), and Amount **OR** Capital Project **OR** Capital Reserve Project Number and Title and Amount:
A.4010.1610 Home Health Agency CHHA revenue
Contract must be electronically signed – will send to the county attorney's office

RESOLUTION NO. 504 OF 2003

Resolution introduced by Supervisors Haskell, Quintal, Montesi, Sheehan and F. Thomas

AUTHORIZING AMENDMENT AGREEMENT WITH U.S. HEALTHCARE, INC., D/B/A AETNA U.S. HEALTHCARE, TO AMEND RATE OF COMPENSATION FOR HOME HEALTH CARE SERVICES - HEALTH SERVICES DEPARTMENT

RESOLVED, that Warren County enter into an amended agreement with U.S. Healthcare, Inc., d/b/a Aetna Health, Inc., 15 Columbia Circle, Albany, New York 12203 (the previous agreement having been authorized by Resolution No. 367 of 2001), to amend the following rates of compensation for home health care services, effective August 1, 2003:

Services of Skilled Nurse in Home Health Setting	$85.00/visit
Nursing Care, in the Home, by Registered Nurse	$85.00/visit
Home Health Aide	$20.00/hour
Services of Physical Therapist in Home Health Setting	$85.00/visit
Services of Occupational Therapist in Home Health Setting	$85.00/visit
Services of Speech & Language Pathologist in Home Health Setting	$85.00/visit
Services of Clinical Social Worker in Home Health Setting	$80.00/visit

and be it further

RESOLVED, that the Chairman of the Board of Supervisors be, and hereby is, authorized to execute said amended agreement in the form approved by the County Attorney.

E:\2003Docs\Resos\030-03.wpd\dlm
8/12/03

ANCILLARY SERVICES AGREEMENT

TABLE OF CONTENTS

ANCILLARY SERVICES AGREEMENT

This Ancillary Services Agreement ("Agreement") is made and entered into as of June 1, 2013 ("Effective Date") by and between Aetna Health Inc., a New York corporation, on behalf of itself and its Affiliates (hereinafter "Company") and Warren County Public Health Services ("Provider"). The New York State Department of Health "Standard Clauses for Managed Care/IPA Provider Contracts," attached to this Agreement as Appendix A, are expressly incorporated into this Agreement and are binding upon the parties to this Agreement. In the event of any inconsistent or contrary language between the Standard Clauses and any other part of this Agreement, including but not limited to appendices, amendments and exhibits, the parties agree that the provisions of the Standard Clauses shall prevail, 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.

WHEREAS, Company offers, issues and administers Full Risk Plans and Plans for Plan Sponsors that provide access to health care services to Members; and

WHEREAS, Company contracts with certain health care providers and facilities to provide access to such health care services to Members; and

WHEREAS, Provider provides health care services to patients within the scope of its licensure or accreditation; and

WHEREAS, Company and Provider mutually desire to enter into an arrangement whereby Provider will become a Participating Provider and render health care services to Members; and

WHEREAS, in return for the provision of health care services by Provider, Company will pay or arrange for the payment of Provider's claims for Covered Services under the terms of this Agreement.

NOW, THEREFORE, in consideration of the foregoing and of the mutual covenants, promises and undertakings herein, the sufficiency of which is hereby acknowledged, and intending to be legally bound hereby, the parties agree as follows:

1.0 DEFINITIONS

When used in this Agreement, all capitalized terms shall have the following meanings:

1.1 AAA. Defined in Section 8.3.1 of this Agreement.

1.2 Aetna Market Fee Schedule. A fee schedule that is expressly incorporated into this Agreement and is binding upon the parties to this Agreement. Aetna Market Fee Schedule ("AMFS") is based upon the contracted location where service is performed. AMFS is available to physicians through the Company's secure provider website via Navinet (or a successor website or tool). Non-physicians or those not able to access online, can obtain a hard copy of the AMFS by faxing a request to Company, along with the desired CPT codes, to Company's Provider Service Center (1-859-455-8650 or a successor number).

1.3 Affiliate. Any corporation, partnership or other legal entity directly or indirectly owned or controlled by, or which owns or controls, or which is under common ownership or control with Company. Company's current Affiliates that may be applicable to this Agreement and offer products consistent with the Product Participation Schedule attached to this Agreement are listed in Exhibit A attached hereto.

1.4 Agreement. Defined in first paragraph of this Agreement.

1.5 Arbitration Record. Defined in Section 8.3.2 of this Agreement.

1.6 Arbitrator. Defined in Section 8.3.1 of this Agreement.

1.7 Award. Defined in Section 8.3.1 of this Agreement.

1.8 Clean Claim. Unless otherwise required by law or regulation, a claim which (a) is submitted within the proper timeframe as set forth in this Agreement and (b) has (i) detailed and descriptive medical and patient data, (ii) a corresponding referral (whether in paper or electronic format), if required for the applicable claim, (iii) whether submitted via an electronic transaction using permitted standard code sets (e.g., CPT-4, ICD-10, HCPCS) as required by the applicable Federal or state regulatory authority (e.g., U.S. Dept. of Health & Human Services, U.S. Dept. of Labor, state law or regulation) or otherwise, all the data elements of the UB-04 or CMS 1500 (or successor standard) forms (including but not limited to Member identification number, national provider identifier ("NPI"), date(s) of service, complete and accurate breakdown of services), and (c) does not involve coordination of benefits, and (d) has no defect or error (including any new procedures with no CPT code, experimental procedures or other circumstances not contemplated at the time of execution of this Agreement) that prevents timely adjudication.

1.9 Coinsurance. The percentage of the lesser of: (a) the rates established under this Agreement; or (b) Provider's usual, customary and reasonable billed charges, which a Member is required to pay for Covered Services under a Plan.

1.10 Company. Defined in first paragraph of this Agreement.

1.11 Confidential Information. Any information that identifies a Member and is related to the Member's participation in a Plan, the Member's physical or mental health or condition, the provision of health care to the Member or payment for the provision of health care to the Member. Confidential Information includes, without limitation, "individually identifiable health information," as defined in 45 C.F.R. § 160.103 and "non-public personal information" as defined in laws or regulations promulgated under the Gramm-Leach-Bliley Act of 1999.

1.12 Copayment. A charge required under a Plan that must be paid by a Member at the time of the provision of Covered Services, or at such other time as determined by Provider.

1.13 Covered Services. Those health care services for which a Member is entitled to receive coverage under the terms and conditions of a Plan.

1.14 Deductible. An amount that a Member must pay for Covered Services during a specified coverage period in accordance with the Member's Plan before benefits will be paid. For purposes of this Agreement (including all schedules and attachments hereto) any reference to Deductibles shall have the same meaning as "permitted deductible."

1.15 Effective Date. Defined in first paragraph of this Agreement.

1.16 Emergency Services. Those services necessary to treat a medical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such 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: (a) placing the health of the individual (or, with respect to a pregnant woman, her pregnancy or health or the health of her fetus) in serious jeopardy or in the case of a behavioral condition placing the health of such person or others in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part; (d) or serious disfigurement of such person; or such other definition as may be required by applicable law.

1.17 Full Risk Plan. A Plan where Company is the underwriter, in full, of the Plan (i.e. fully-insured Plans).

1.18 Government Programs. Defined in Section 2.3.2 of this Agreement.

1.19 HIPDB. Defined in Section 2.3.1 of this Agreement.

1.20 Information. Defined in Section 5.3.2 of this Agreement.

1.21 Initial Term. Defined in Section 6.1 of this Agreement.

1.22 License. Defined in Section 3.2 of this Agreement.

1.23 Material Change. Any change in Policies or compensation arrangement applicable to this Agreement, including Aetna Market Fee Schedule (or other applicable fee schedule) that could reasonably be expected to have a material adverse impact on (i) Provider's reimbursement for Provider Services or (ii) Provider administration.

1.24 Member. An individual covered by or enrolled in a Plan.

1.25 NPDB. Defined in Section 2.3.1 of this Agreement.

1.26 Negotiation Record. Defined in Section 8.3.2 of this Agreement.

1.27 Participating Provider. Any physician, hospital, hospital-based physician, skilled nursing facility, mental health and/or substance abuse professional (which shall include psychiatrists, psychologists, social workers, psychiatric nurses, counselors, family or other therapists or other mental health/substance abuse professionals), or other individual or entity involved in the delivery of health care or ancillary services who or which has entered into and continues to have a current valid contract with Company to provide Covered Services to Members, and, where applicable, has been credentialed by Company or its designee consistent with Company's credentialing policies. Certain categories of Participating Providers may be referred to herein more specifically as, e.g., "Participating Physicians" or "Participating Hospitals."

1.28 Party. Company or Provider, as applicable.

1.29 Plan. A Member's health care benefits as set forth in the Member's Summary Plan Description, Certificate of Coverage or other applicable coverage document.

1.30 Plan Sponsor. An employer, insurer, third party administrator, labor union, organization or other person or entity which has contracted with Company to offer, issue and/or administer a Plan that is not a Full Risk Plan and has agreed to be responsible for funding benefit payments for Covered Services provided to Members under the terms of a Plan.

1.31 Policies. The policies and procedures promulgated by Company which relate to this Agreement, including, but not limited to: (a) quality improvement/management; (b) utilization management, including, but not limited to, precertification of elective admissions and procedures, concurrent review of services and referral processes or protocols; (c) pre-admission testing guidelines; (d) claims payment review; (e) member grievances; (f) provider credentialing; (g) electronic submission of claims and other data required by Company; and (h) any applicable Participation Criteria for outpatient services, as set forth in the **Participation Criteria Schedules** attached hereto and made a part hereof. Policies also include those policies and procedures set forth in the Company's manuals, Health Care Professional Toolkit or their successors (as modified from time to time); Clinical Policy Bulletins made available via Company's internet web site; and other policies and procedures, whether made available via a password-protected web site for Participating Providers (when available), by letter, newsletter, electronic mail or other media.

1.32 Proprietary Information. Any and all information, whether prepared by a Party, its advisors or otherwise, relating to such Party or the development, execution or performance of this Agreement whether furnished prior to or after the Effective Date. Proprietary Information includes but is not limited to, with respect to Company, the development of a pricing structure, (whether written or oral) all financial information, rate

schedules and financial terms which relate to Provider and which are furnished or disclosed to Provider by Company. Notwithstanding the foregoing, the following shall not constitute Proprietary Information:

(a) information which was known to a receiving Party (a "Recipient") prior to receipt from the other Party (a "Disclosing Party") (as evidenced by the written records of a Recipient);
(b) information which was previously available to the public prior to a Recipient's receipt thereof from a Disclosing Party;
(c) information which subsequently became available to the public through no fault or omission on the part of a Recipient, including without limitation, the Recipient's officers, directors, trustees, employees, agents, contractors and other representatives;
(d) information which is furnished to a Recipient by a third party which a Recipient confirms, after due inquiry, has no confidentiality obligation, directly or indirectly, to a Disclosing Party; or
(e) information which is approved in writing in advance for disclosure or other use by a Disclosing Party.

1.33 Provider. Defined in first paragraph of this Agreement.

1.34 Provider Services. Defined in Section 2.1 of this Agreement.

1.35 Records. Defined in Section 5.3.2 of this Agreement.

1.36 Specialty Program. A Company established program for a targeted group of Members with certain types of illnesses, conditions, cost or risk factors (e.g., organ transplants, women's health, other disease management programs, etc).

1.37 Specialty Program Providers. Those hospitals, physicians and other providers that have been identified or designated by Company to provide transplant services and other Covered Services associated with a Specialty Program.

2.0 PROVIDER SERVICES AND OBLIGATIONS

2.1 Provision of Services.
Provider will make available and provide to Members those services and any related facilities, equipment, personnel or other resources necessary to provide the services according to generally accepted standards of Provider's practice ("Provider Services") and accepts the compensation for such Provider Services listed and set forth in the **Services and Compensation Schedule** attached hereto and made a part hereof. Company and Provider may mutually agree in writing at any time, and from time to time, either to increase or decrease the Provider Services made available to Members under this Agreement.

2.2 Non-Discrimination.

2.2.1 Equitable Treatment of Members. Provider agrees to provide Provider Services to Members with the same degree of care and skill as customarily provided to Provider's patients who are not Members, according to generally accepted standards of Provider's practice. Provider and Company agree that Members and non-Members should be treated equitably; to that end Provider agrees not to discriminate against Members on the basis of race, gender, creed, ancestry, lawful occupation, age, religion, marital status, sexual orientation, mental or physical disability, color, national origin, place of residence, health status, source of payment for services, cost or extent of Provider Services required, or any other grounds prohibited by law or this Agreement.

2.2.2 Affirmative Action. Company is a Federal contractor and an Equal Opportunity Employer which maintains an Affirmative Action Program. To the extent applicable to Provider, Provider, on behalf of itself and any subcontractors, agrees to comply with the following, as amended from time to time: Executive Order 11246, the Vietnam Era Veterans Readjustment Act of 1974, the Drug Free Workplace Act of 1988, Section 503 of the Rehabilitation Act of 1973, Title VI of the Civil Rights Act

of 1964, the Age Discrimination Act of 1975, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") administrative simplification rules at 45 CFR parts 160, 162, and 164, the Americans with Disabilities Act of 1990, Federal laws, rules and regulations designed to prevent or ameliorate fraud, waste, and abuse, including, but not limited to, applicable provisions of Federal criminal law, the False Claims Act (31 U.S.C. 3729 et. seq.), and the anti-kickback statute (Section 1128B(b) of the Social Security Act), and any similar laws, regulations or other legal mandates applicable to recipients of federal funds and/or transactions under or otherwise subject to any government contract of Company.

2.3 Provider Representations.

2.3.1 General Representations. Provider represents, warrants and covenants, as applicable, that: (a) it has and shall maintain throughout the term of this Agreement all appropriate license(s) and certification(s) mandated by governmental regulatory agencies; (b) it is, and will remain throughout the term of this Agreement, accredited by The Joint Commission ("TJC") or another applicable accrediting agency recognized by Company; (c) it is, and will remain throughout the term of this Agreement, in compliance with all applicable Federal and state laws and regulations related to this Agreement and the services to be provided hereunder, including, without limitation, statutes and regulations related to fraud, abuse, discrimination, disabilities, confidentiality, false claims and prohibition of kickbacks; (d) it is certified to participate in the Medicare program; (e) it has established an ongoing quality assurance/assessment program which includes, but is not limited to, credentialing of employees and subcontractors and shall supply to Company the relevant documentation, including, but not limited to, internal quality assurance/assessment protocols, state licenses and certifications, Federal agency certifications and/or registrations upon request; (f) all health care personnel employed by, associated or contracted with Provider who treat Members: (i) are and will remain throughout the term of this Agreement appropriately licensed and/or certified (when and as required by state law) and supervised, and qualified by education, training and experience to perform their professional duties; and (ii) will act within the scope of their licensure or certification, as the case may be; (g) in no event shall Provider, without Company's prior written approval, perform Covered Services through employees or agents, including a subcontractor, if such employee, agent or subcontractor is physically located outside of the United States of America; and (h) its credentialing, privileging, and re-appointment procedures are in accordance with its medical staffs by-laws, regulations, and policies, comply with TJC standards, meet the querying and reporting requirements of the National Practitioner Data Bank ("NPDB") and Healthcare Integrity and Protection Data Bank ("HIPDB"), and fulfill all applicable state and Federal standards; (i) this Agreement has been executed by its duly authorized representative; and (j) executing this Agreement and performing its obligations hereunder shall not cause Provider to violate any term or covenant of any other agreement or arrangement now existing or hereinafter executed.

2.3.2 Government Program Representations. Company has or may seek a contract to serve Medicare and Medicaid beneficiaries ("Government Programs"). To the extent Company participates in such Government Programs, Provider agrees, on behalf of itself and any subcontractors of Provider acting on behalf of Provider, to be bound by all rules and regulations of, and all requirements applicable to, such Government Programs. Provider acknowledges and agrees that all provisions of this Agreement shall apply equally to any employees, independent contractors and subcontractors of Provider who provide or may provide Covered Services to Members of Government Programs, and Provider represents and warrants that Provider shall take all steps necessary to cause such employees, independent contractors and subcontractors to comply with the Agreement and all applicable laws, rules and regulations and perform all requirements applicable to Government Programs. With respect to Members of Government Programs, Provider acknowledges that compensation under this Agreement for such Members constitutes receipt of Federal funds. Provider agrees that all services and other activities performed by Provider under this Agreement will be consistent and comply with Company's obligations under its contract(s) with the Centers for Medicare and Medicaid Services ("CMS"), and any applicable state regulatory agency, to offer Medicare/Medicaid Plans. Provider further agrees to allow CMS, any applicable state regulatory agency, and Company to monitor

Providers' performance under this Agreement on an ongoing basis in accordance with Medicare/Medicaid laws, rules and regulations. Provider acknowledges and agrees that Company may only delegate its activities and responsibilities under its contract(s) with CMS and any applicable regulatory agency, to offer Medicare/Medicaid Plans in a manner consistent with Medicare/Medicaid laws, rules and regulations, and that if any such activity or responsibility is delegated by Company to Provider, the activity or responsibility may be revoked if CMS or Company determine that Provider has not performed satisfactorily.

2.4 Provider's Insurance.
During the term of this Agreement, Provider agrees to procure and maintain such policies of general and professional liability and other insurance or a comparable program of self-insurance, at minimum levels required by state law or, in the absence of a state law specifying a minimum limit, an amount customarily maintained by providers in the state or region in which the Provider operates. Such insurance coverage shall cover the acts and omissions of Provider as well as those of Provider's agents and employees. Provider agrees to deliver certificates of insurance or other documentation as appropriate to show evidence of such coverage to Company upon request. Provider agrees to make best efforts to provide to Company at least thirty (30) days advance notice, and in any event will provide notice as soon as reasonably practicable, of any cancellation or material modification of said policies.

2.5 Product Participation.
Provider agrees to participate in the benefit products listed on the **Product Participation Schedule** attached hereto and made a part hereof. Company reserves the right to introduce and designate Provider's participation in new Specialty Programs and products during the term of this Agreement and will provide Provider with written notice of such new Specialty Programs and products and the associated compensation. Company shall notify Provider of any new Affiliate that may be applicable to this Agreement and offer products consistent with the Product Participation Schedule attached to this Agreement as listed in Exhibit A attached hereto. Provider shall have thirty (30) days from receipt of the aforementioned notice from Company to notify Company in writing to object to participate with any Plans offered by such new Affiliate.

Nothing herein shall require that Company identify, designate or include Provider as a preferred participant in any specific Specialty Program or product; provided, however, Provider shall accept compensation in accordance with this Agreement for the provision of any Covered Services to Members under a Specialty Program or product in which Provider has agreed to participate hereunder.

Company may sell, lease, transfer or otherwise convey to payers (other than Plan Sponsors) which do not compete with Company's product offerings (e.g., workers' compensation or automobile insurers) in the geographic area where Provider provides Covered Services, the benefits of this Agreement, including, without limitation, the **Services and Compensation Schedule** attached hereto, under terms and conditions which will be communicated to Provider in each such case. For those programs and products which are not health benefit products (e.g., worker's compensation or auto insurance), Provider shall have thirty (30) days from receipt of the aforementioned notice from Company to notify Company in writing if Provider elects not to participate in such product(s).

2.6 Consents to Release Medical Information.
Provider covenants that it will obtain from Members to whom Provider Services are provided, any necessary consents or authorizations to the release of Information and Records to Company, Plan Sponsors, their agents and representatives in accordance with any applicable Federal and state law or regulation.

3.0 COMPANY OBLIGATIONS

3.1 Company's Covenants.
Company or Plan Sponsors shall provide Members with a means to identify themselves to Provider (e.g., identification cards), explanation of provider payments, a general description of products (e.g. Quick Reference Card), a listing of Participating Providers, and timely notification of material changes in this information. Company shall provide Provider with a means to check eligibility. Company shall include

Provider in the Participating Provider directory or directories for the Plans, Specialty Programs and products in which Provider is a Participating Provider, including when Provider is designated as preferred participant, and shall make said directories available to Members. Company reserves the right to determine the content of provider directories.

3.2 Company Representations.
Company represents and warrants that: (a) it, where applicable, is licensed to offer, issue and administer Plans in the service areas covered by this Agreement by the applicable regulatory authority ("License"); (b) it will not lose such License involuntarily during the course of this Agreement; (c) it is, and will remain throughout the term of this Agreement, substantially in compliance with all applicable Federal and state laws and regulations related to this Agreement and the services to be provided hereunder; including without limitation, any applicable prompt payment statutes and regulations or capital reserve requirements; provided however, that for the purposes of (b) and (c), Provider will have no basis for termination to the extent that such action does not impact the obligations of Company under this Agreement; (d) this Agreement has been executed by its duly authorized representative; and (e) executing this Agreement and performing its obligations hereunder shall not cause Company to violate any term or covenant of any other agreement or arrangement now existing or hereinafter executed.

3.3 Company's Insurance.
Company at its sole cost and expense agrees to procure and maintain such policies of general and/or professional liability and other insurance (or maintain a self-insurance program) as shall be necessary to insure Company and its employees against any claim or claims for damages arising by reason of personal injuries or death occasioned directly or indirectly in connection with the performance of any service by Company under this Agreement and the administration of Plans.

4.0 CLAIMS SUBMISSIONS, COMPENSATION AND MEMBER BILLING

4.1 Claim Submission and Payment.

4.1.1 Provider Obligation to Submit Claims. Provider agrees to submit Clean Claims to Company for Provider Services rendered to Members. Provider represents that, where necessary, it has obtained signed assignments of benefits authorizing payment for Provider Services to be made directly to Provider. Provider will submit all claims electronically to Company using the HIPAA required ASC X12N 837—Health Care Claim: Professional for professional claims and the ASC X12N 837—Health Care Claim: Institutional for institutional claims or an industry standard successor format ("Electronic Claim"). Provider shall not submit a claim to Company in paper form unless Company fails to pay or otherwise respond to electronic claims submission in accordance with the time frames required under this Agreement or applicable law or regulation. Provider agrees that Company, or the applicable Plan Sponsor, will not be obligated to make payments for billings received more than one hundred and twenty (120) days from (a) the date of service or, (b) when Company is the secondary payer, from the date of receipt of the primary payer's explanation of benefits. This requirement will be waived in the event Provider provides notice to Company, along with appropriate evidence, of other extraordinary circumstances outside the control of Provider that resulted in the delayed submission. Payment for claims submitted after one hundred and twenty (120) days, may be reduced by twenty-five (25) percent. In addition, unless Provider notifies Company of any payment disputes within one hundred eighty (180) days or such longer time as required by applicable state law or regulation, of receipt of payment from Company, such payment will be considered full and final payment for the related claims. If Provider does not bill Company or Plan Sponsors, or disputes any payment, timely as provided in this section 4.1.1, Provider's claim for payment will be deemed waived and Provider will not seek payment from Plan Sponsors, Company or Members. Provider shall pay on a timely basis all employees, independent contractors and subcontractors who render Covered Services to Members of Company's Medicare/Medicaid Plans for which Provider is financially responsible pursuant to this Agreement.

Provider agrees to permit rebundling to the primary procedure those services considered part of, incidental to, or inclusive of the primary procedure and make other adjustments for inappropriate billing or coding (e.g., duplicative procedures or claim submissions, mutually exclusive procedures, gender/procedure mismatches, age/procedure mismatches). In performing rebundling and making adjustments for inappropriate billing or coding, Company utilizes a commercial software package (as modified by Company for all Participating Providers in the ordinary course of Company's business) which commercial software package relies upon Medicare/Medicaid and other industry standards in the development of its rebundling logic.

4.1.2 Company Obligation to Pay for Covered Services. Company agrees to: (a) pay Provider for Covered Services rendered to Members of Full Risk Plans, and (b) notify Plan Sponsors to forward payment to Company for payment to Provider for Covered Services rendered to a Plan Sponsor's Members, according to the lesser of (1) Provider's actual billed charges or (2) the rates set forth in the **Services and Compensation Schedule** attached hereto and made a part hereof and is expressly incorporated into this Agreement and is binding upon the parties to this Agreement, within thirty (30) days receipt of an electronic Clean Claim or forty-five (45) days of actual receipt by Company of a paper Clean Claim or such time as permitted by applicable law or regulation of actual receipt by Company of a Clean Claim.

Company will provide ninety (90) days prior notice of a Material Change to the Services and Compensation Schedule, including any change to Aetna Market Fee Schedule (if applicable) that results in an adverse reimbursement change where adverse reimbursement change is one that could reasonable be expected to have an adverse impact on the aggregate level of payment to a health care professional. If Provider objects to the Material Change Provider may within thirty (30) calendar days of the date of the notice give written notice of termination of this Agreement to Company to be effective coincident of the effective date of the Material Change. Such written notice shall be sent to Provider either by email if Provider has email capabilities or hard copy if Provider is without email capabilities. Such notices will specify the updates or Material Changes and information on where and how Provider can access a schedule of specific updates or Material Changes, as well as the effective date of updates or Material Changes. Provider may also view the updates or Material Changes ninety (90) days in advance of the effective date of updates or Material Changes via Navinet (or a successor website or tool) or obtain a hard copy of the updates or Material Changes by calling or faxing a request to Company, along with the desired CPT codes, to Company's Provider Service Center (1-859-455-8650 or a successor number).

Capitation shall be used by a Payor as a method of compensation only to the extent permitted by New York law. Provider will utilize online explanation of benefits, electronic remittance of advice and electronic funds transfer in lieu of receiving paper equivalents. While Company may pay claims on behalf of Plan Sponsors, Provider and Company acknowledge that Company has no legal responsibility for the payment of such claims for Covered Services rendered to a Plan Sponsor's Members; provided, however, that Company agrees to reasonably assist Provider as appropriate in collecting any such payments. Company and/or its designee may, from time to time, notify Provider of overpayments to Provider, and Provider agrees to cooperate with Company and/or its designee to secure the return of any such overpayment or payment made in error (e.g., a duplicate payment or payment for services rendered by Provider to a patient who was not a Member) within a reasonable period of time. In the event Company is unable to secure the return of any such payment within such reasonable time, Company reserves the right to offset such payment against any other monies due to Provider under this Agreement provided Company has delivered to Provider at least thirty (30) days prior written notice and Provider has otherwise failed to return such payment to Company. Company shall not initiate overpayment recovery efforts more than twenty-four (24) months after the original payment; provided that no time limit shall apply to initiation of overpayment recovery efforts based on reasonable suspicion of fraud or other intentional misconduct or initiated at the request of a Plan Sponsor, and in the event that Provider asserts a claim of underpayment Company may defend or set off such claim based on overpayments going back in time as far as the claimed underpayment. To the extent, if any, that the compensation under certain Plans is in the form of capitation payments or a

case-based rate methodology, Provider acknowledges the financial risks to Provider of this arrangement and has made an independent analysis of the adequacy of this arrangement. Provider, therefore, agrees and covenants not to bring any action asserting the inadequacy of these arrangements or that Provider was in any way improperly induced by Company to accept the rate of payment, including, but not limited to, causes of actions for damages, rescission or termination alleging fraud or negligent misrepresentation or improper inducement. Notwithstanding anything in this Agreement to the contrary, subcontractors agree to seek compensation solely from Provider for those Covered Services provided to Members and for which Provider is compensated by Company. Subcontractor shall in no event bill Company, its Affiliates, Payers or Members for any such Covered Services. Provider will provide Company with a Designation of Payment Schedule from all subcontractors, which will indemnify and hold harmless Company and its Members for payment of all compensation owed subcontractor under subcontractor's arrangement with Provider.

4.1.3 Utilization Management. Company utilizes systems of utilization review/quality improvement/peer review to promote adherence to accepted medical treatment standards and to encourage Participating Providers to minimize unnecessary medical costs consistent with sound medical judgment. To further this end, Provider agrees, consistent with sound medical judgment:

(a) To participate, as requested, and to abide by Company's utilization review, patient management, quality improvement programs, and all other related programs (as modified from time to time) and decisions with respect to all Members.

(b) To comply with Company's precertification and utilization management requirements for those Covered Services requiring such notice.

(c) To regularly interact and cooperate with Company's nurse case managers.

(d) To utilize Participating Providers, including but not limited to Participating surgery centers and hospitals to the fullest extent possible, consistent with sound medical judgment.

(e) To abide by all Company's credentialing criteria and procedures, including site visits and medical chart reviews, and to submit to these processes biannually, annually, or otherwise, when applicable.

To obtain advance authorization from Company prior to any non-emergency admission, and in cases where a Member requires an emergency hospital admission, to notify Company, both in accordance with Company's rules, policies and procedures then in effect.

For those Members who require services under a Specialty Program, Provider agrees to work with Company in transferring the Member's care to a Specialty Program Provider.

4.2 Coordination of Benefits.
Company will coordinate benefits as allowed by state or federal law, or, in the absence of any applicable law, in accordance with plan requirements. If Medicare is the primary payer under coordination of benefit principles, Provider may not collect more than Medicare allows. In no event will Company pay more than the compensation due under this agreement.

4.3 Member Billing.

4.3.1 Permitted Billing of Members. Provider may bill or charge Members only in the following circumstances: (a) applicable Copayments, Coinsurance and/or permitted Deductibles not collected at the time that Covered Services are rendered; (b) a Plan Sponsor becomes insolvent or otherwise fails to pay Provider in accordance with applicable Federal law or regulation (e.g., ERISA) provided that Provider has first exhausted all reasonable efforts to obtain payment from the Plan Sponsor, however, this Section 4.3.1 (b) is not applicable to Medicaid Members; and (c) services that are not Covered

Services only if: (i) the Member's Plan provides and/or Company confirms that the specific services are not covered; (ii) the Member was advised in writing prior to the services being rendered that the specific services may not be Covered Services; and (iii) the Member agreed in writing to pay for such services after being so advised. Notwithstanding the foregoing, Provider will bill or charge Member contracted rates if the Member has exhausted applicable plan benefits. Provider acknowledges that Company's denial or adjustment of payment to Provider based on Company's performance of utilization management as described in Section 4.1.3 or otherwise is not a denial of Covered Services under this Agreement or under the terms of a Plan, except if Company confirms otherwise under this Section 4.3. Provider may bill or charge individuals who were not Members at the time that services were rendered.

4.3.2 Holding Members Harmless. Provider hereby agrees that in no event, including, but not limited to the failure, denial or reduction of payment by Company, insolvency of Company or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse (i) against Members, a Member's family members or persons acting on their behalf (other than Company) or (ii) any settlement fund or other asset controlled by or on behalf of, or for the benefit of, a Member for services provided pursuant to this Agreement. This provision shall not prohibit collection of Copayments, Coinsurance, permitted Deductibles or other supplemental charges made in accordance with the terms of the applicable Plan. Provider further agrees that this Section 4.3.2: (a) shall survive the expiration or termination of this Agreement regardless of the cause giving rise to termination and shall be construed for the benefit of Members; and (b) supersedes any oral or written contrary agreement or waiver now existing or hereafter entered into between Provider and Members or persons acting on their behalf.

4.3.3 Cost Sharing Protections for Dual Eligible Members. Provider acknowledges and agrees that Medicare Members who are also enrolled in a State Medicaid plan ("Dual Eligible Members") are not responsible for paying to Provider any Copayments, Coinsurance or Deductibles for Medicare Part A and Part B services ("Cost Sharing Amounts") when the State Medicaid plan is responsible for paying such Cost Sharing Amounts. Provider further agrees that they will not collect Cost Sharing Amounts from Dual Eligible Members when the State is responsible for paying such Cost Sharing Amounts, and will, instead, either accept the Company's payment for Covered Services as payment in full for Covered Services and applicable Cost Sharing Amounts, or bill the applicable State Medicaid plan for the appropriate Cost Sharing Amounts owed by the State Medicaid plan.

To protect Members, Provider agrees not to seek or accept or rely upon waivers of the Member protections provided by this Section 4.3.

4.4 Risk Adjustment Data Validation.

In the event Government Programs pertains to this Agreement and for purposes of this Section, "risk adjustment data" shall have the meaning set forth in 42 C.F.R. Section 422.310(a), as may be amended from time to time. Company is required to obtain risk adjustment data from Provider for Medicare Members, and Provider agrees to provide complete and accurate risk adjustment data to Company for Medicare Members that conforms to all standards and requirements set forth in applicable laws, rules and regulations and/or CMS instructions that apply to risk adjustment data. Provider certifies, based on best knowledge, information and belief, that any risk adjustment data that Provider submits to Company for Medicare Members is accurate, complete and truthful. Provider agrees to immediately notify Company if any risk adjustment data that was submitted to Company for Medicare Members is erroneous, and follow procedures established by Company to correct erroneous risk adjustment data to ensure Company's compliance with applicable laws, rules and regulations and CMS instructions.

Provider further agrees to maintain accurate, legible and complete medical record documentation for all risk adjustment data submitted to Company for Medicare Members in a format that meets all standards and requirements set forth in applicable laws, rules, regulations and/or CMS instructions, and allows any federal governmental authorities with jurisdiction or their designees ("Government Officials") to: (1) confirm that the appropriate diagnoses codes and level of specificity are documented; (2) verify the date of service is

documented and within the risk adjustment data collection period; and (3) confirm that the appropriate provider's signature and credentials are present ("Medical Records").

Provider agrees to provide Company and Government Officials, or their designees, with medical records and any other information or documentation required by Government Officials for the validation of risk adjustment data ("Audit Data"). Provider agrees to provide Company with Audit Data within the timeframe established by Company to ensure Company's compliance with deadlines imposed by Government Officials for the submission of Audit Data. In the event that CMS conducts a review that includes the validation of risk adjustment data submitted by Provider, Company will submit to Provider a copy of the CMS written notice of such review, along with a written request from Company for Audit Data.

When Provider is compensated on a fee for services basis and if a Government Official imposes a financial adjustment or penalty on Company based on a determination that there is insufficient information or documentation to support an International Classification of Diseases, 9th Revision, Clinical Modification ("ICD-9-CM") diagnosis submitted by Provider to Company for a Medicare Member ("Diagnosis"), Company may recoup the total amount that Company paid to Provider for the Current Procedural Terminology (CPT) codes associated with the Diagnosis for the dates of service in question, for which that Diagnosis was listed.

5.0 COMPLIANCE WITH POLICIES

5.1 Policies.

Provider agrees to accept and comply with Policies (e.g., Clinical Policy Bulletins or other Policies made available to Participating Providers). Except when a Member requires Emergency Services, Provider agrees to comply with any applicable precertification and/or referral requirements under the Member's Plan prior to the provision of Provider Services. Provider will utilize the electronic real time HIPAA compliant transactions, including but not limited to, eligibility, precertification and claim status inquiry transactions. Provider agrees to notify Company of all admissions of Members, and of all services for which Company requires notice, upon admission or prior to the provision of such services. For the purpose of pre-admission testing, Provider agrees to directly provide testing or accept test results and examinations performed outside Provider provided such tests and examinations are: (a) performed by a state licensed laboratory for laboratory tests and a licensed physician for such other tests and examinations; and (b) performed within a time reasonably proximate to the admission. For those Members who require services under a Specialty Program, Provider agrees to work with Company in transferring the Member's care to a Specialty Program Provider, as the case may be. Company may at any time modify Policies. Company will provide ninety (90) days prior notice by letter, newsletter, electronic mail or other media, of Material Changes. Failure by Provider to object in writing to any Material Change within thirty (30) days following receipt thereof constitutes Provider's acceptance of such Material Change. In the event that Provider reasonably believes that a Material Change is likely to have a material adverse financial impact upon Provider, Provider agrees to notify Company, specifying the specific bases demonstrating a likely material adverse financial impact, and the Parties will negotiate in good faith an appropriate amendment, if any, to this Agreement. If the parties are unable to negotiate any such amendment and Provider provides notice of termination of this Agreement not more than thirty (30) calendar days after receipt of a Material Change, then this Agreement shall terminate coincident with the effective date of the Material Change. Provider agrees that noncompliance with any requirements of this Section 5.1 or any Policies will relieve Company or Plan Sponsors and Members from any financial liability for the applicable portion of the Provider Services.

5.2 Notices and Reporting.

To the extent neither prohibited by law nor violative of applicable privilege, Provider agrees to provide notice to Company, and shall provide all information reasonably requested by Company regarding the nature, circumstances, and disposition, of: (a) any action taken by Provider adversely affecting medical staff membership of Participating Physicians and other Participating Providers, whether or not such actions are reportable to NPDB or HIPDB; (b) any litigation brought against Provider or any of its employees, medical staff members or affiliated providers which is related to the provision of health care services and could have a

material impact on the Provider Services provided to Members; (c) any investigation initiated by TJC, another accrediting agency recognized by Company or any government agency or program against or involving Provider or any of its employees, medical staff members or affiliated providers that does or could adversely affect Provider's accreditation status, licensure, or certification to participate in the Medicare or Medicaid programs; (d) any change in the ownership or management of Provider; and (e) any material change in services provided by Provider or licensure status related to such services, including without limitation a significant decrease in medical staff or the closure of a service unit or material decrease in beds. Provider agrees to use best efforts to provide Company with prior notice of, and in any event will provide notice as soon as reasonably practicable notice of, any actions taken by Provider described in this Section 5.2.

5.3 Information and Records.

5.3.1 Maintenance of Information and Records. Provider agrees (a) to maintain Information and Records (as such terms are defined in Section 5.3.2) in a current, detailed, organized and comprehensive manner and in accordance with customary medical practice, applicable Federal and state laws, and accreditation standards; (b) that all Member medical records and Confidential Information shall be treated as confidential and in accordance with applicable laws; (c) to maintain such Information and Records for the longer of: (i) six (6) years after the last date Provider Services were provided to Member; (ii) in the case of Members who are minors, for three (3) years after the age of majority or six (6) years from after the last date Provider Services were provided; or (iii) the period required by state law. This Section 5.3.1 shall survive the termination of this Agreement, regardless of the cause of the termination.

5.3.2 Access to Information and Records. Provider agrees that (a) Company (including Company's authorized designee) and Plan Sponsors shall have access to all data and information obtained, created or collected by Provider related to Members and necessary for payment of claims, including without limitation Confidential Information ("Information"); (b) Company (including Company's authorized designee), Plan Sponsors and Federal, state, and local governmental authorities and their agents having jurisdiction, upon request, shall have access to all books, records and other papers (including, but not limited to, contracts, medical and financial records and physician incentive plan information) and information relating to this Agreement and to those services rendered by Provider to Members ("Records"); (c) consistent with the consents and authorizations required by Section 2.6 hereof, Company or its agents or designees shall have access to medical records for the purpose of assessing quality of care, conducting medical evaluations and audits, and performing utilization management functions; (d) applicable Federal and state authorities and their agents shall have access to medical records for assessing the quality of care or investigating Member grievances or complaints; and (e) Members shall have access to their health information as required by 45 C.F.R. § 164.524 and applicable state law, be provided with an accounting of disclosures of information when and as required by 45 C.F.R. § 164.528 and applicable state law, and have the opportunity to amend or correct the information as required by 45 C.F.R. § 164.526 and applicable state law. Provider agrees to supply copies of Information and Records within fourteen (14) days of the receipt of a request, where practicable, and in no event later than the date required by any applicable law or regulatory authority. Provider agrees to supply such information at no charge to the New York Department of Health. Notwithstanding any other provision in this Agreement to the contrary, medical records of all Members will be made available to the New York Department of Health for purposes of inspection and copying at no charge to the Department. This Section 5.3.2 shall survive the termination of this Agreement, regardless of the cause of termination.

5.3.3 Government Requirements Regarding Records for Medicare Members. In addition to the requirements of Sections 5.3.1 and 5.3.2, with respect to Medicare Plans, Provider agrees to maintain Information and Records (as those terms are defined in Section 5.3) for the longer of: (i) ten (10) years from the end of the final contract period of any government contract of Company, (ii) the date the U.S. Department of Health and Human Services ("HHS"), the U.S. Comptroller General, or their designees complete an audit, or (iii) the period required by applicable laws, rules or regulations. Provider further agrees that, with respect to Medicare Plans, Company and Federal, state and local government

authorities having jurisdiction, or their designees, upon request, shall have access to all Information and Records, and that this right of inspection, evaluation and audit of Information and Records shall continue for the longer of (i) ten (10) years from the end of the final contract period of any government contract of Company, (ii) the date HHS, the U.S. Comptroller General, or their designee complete an audit, or (iii) the period required by applicable laws, rules or regulations. This Section 5.3.3 shall survive the termination of this Agreement, regardless of the cause of termination.

5.4 Quality, Accreditation and Review Activities.
Provider agrees to cooperate with any Company quality activities or review of Company or a Plan conducted by the National Committee for Quality Assurance (NCQA) or a state or Federal agency with authority over Company and/or the Plan, as applicable.

5.5 Proprietary Information.

5.5.1 Rights and Responsibilities. Each Party agrees that the Proprietary Information of the other Party is the exclusive property of such Party and that each Party has no right, title or interest in the same. Each Party agrees to keep the Proprietary Information and this Agreement strictly confidential and agrees not to disclose any Proprietary Information or the contents of this Agreement to any third party without the other Party's consent, except (i) to governmental authorities having jurisdiction, (ii) in the case of Company's disclosure, to Members Plan Sponsors, consultants and vendors under contract with Company, and (iii) in the case of Provider's disclosure to Members for the purposes of advising Members of potential treatment options and costs. Except as otherwise required under applicable Federal or state law, each Party agrees to not use any Proprietary Information of the other Party, and at the request of the other Party hereto, return any Proprietary Information upon termination of this Agreement for whatever reason. Notwithstanding the foregoing, Provider is encouraged to discuss Company's provider payment methodology with patients, including descriptions of the methodology under which the Provider is paid. Provider is encouraged to discuss Company's provider payment methodology with their patients, including descriptions of the methodology under which the Provider is paid. In addition, Provider through its staff may freely communicate with patients about their treatment options, regardless of benefit coverage limitations. This Section 5.5.1 shall survive the termination of this Agreement for one (1) year, regardless of the cause of termination.

6.0 TERM AND TERMINATION

6.1 Term.
This Agreement shall be effective for an initial term ("Initial Term") of three (3) year(s) from the Effective Date, and thereafter shall automatically renew for additional terms of one (1) year each, unless and until terminated in accordance with this Article 6.0 or unless non-renewed as of the anniversary date of the Effective Date by either Party with at least sixty (60) days prior written notice to Provider, provided; however, that no nonrenewal shall be effective during the Initial Term hereof.

6.2 Termination without Cause.
This Agreement may be terminated as of the anniversary date of the Effective Date, by either Party with at least one hundred eighty (180) days prior written notice to the other Party prior to such anniversary date of the Effective Date; provided, however, that no termination of this Agreement pursuant to this Section 6.2 shall be effective during the Initial Term hereof. Company shall give Provider a written explanation of the reason(s) for the termination and an opportunity for a review or hearing. In addition to the foregoing, Provider may terminate this Agreement in accordance with the provisions of Sections 4.1.2 and 5.1.

6.3 Termination for Breach.
This Agreement may be terminated at any time by either Party upon at least sixty (60) days prior written notice of such termination to the other Party upon material default or substantial breach by such Party of one or more of its obligations hereunder, unless such material default or substantial breach is cured within sixty (60) days of the notice of termination; provided, however, if such material default or substantial breach is

the termination of this Agreement shall be stayed and the Parties shall continue to perform under the terms of this Agreement until the final resolution of the dispute.

7.0 RELATIONSHIP OF THE PARTIES

7.1 Independent Contractor Status.
The relationship between Company and Provider, as well as their respective employees and agents, is that of independent contractors, and neither shall be considered an agent or representative of the other Party for any purpose, nor shall either hold itself out to be an agent or representative of the other for any purpose. Company and Provider will each be solely liable for its own activities and those of its agents and employees, and neither Company nor Provider will be liable in any way for the activities of the other Party or the other Party's agents or employees arising out of or in connection with: (a) any failure to perform any of the agreements, terms, covenants or conditions of this Agreement; (b) any negligent act or omission or other misconduct; (c) the failure to comply with any applicable laws, rules or regulations; or (d) any accident, injury or damage. Provider acknowledges that all Member care and related decisions are the responsibility of Provider and its medical staff, and that Policies do not dictate or control Provider's clinical decisions with respect to the care of Members. Provider agrees to indemnify and hold harmless the Company from any and all claims, liabilities and third party causes of action arising out of the Provider's provision of care to Members. Company agrees to indemnify and hold harmless the Provider from any and all claims, liabilities and third party causes of action arising out of the Company's administration of Plans. This provision shall survive the expiration or termination of this Agreement, regardless of the reason for termination.

7.2 Use of Name.
Provider consents to the use of Provider's name and other identifying and descriptive material in provider directories and in other materials and marketing literature of Company in all formats, including, but not limited to, electronic media. Provider may use Company's names, logos, trademarks or service marks in marketing materials or otherwise, upon receipt of Company's prior written consent, which shall not be unreasonably withheld.

7.3 Interference with Contractual Relations.
Provider shall not engage in activities that will cause Company to lose existing or potential Members, including but not limited to: (a) advising Company customers, Plan Sponsors or other entities currently under contract with Company to cancel, or not renew said contracts; (b) impeding or otherwise interfering with negotiations which Company is conducting for the provision of health benefits or Plans; or (c) using or disclosing to any third party membership lists acquired during the term of this Agreement for the purpose of soliciting individuals who were or are Members or otherwise to compete with Company. Nothing in this Section 7.3 is intended or shall be deemed to restrict (i) any communication between Provider and a Member determined by Provider to be necessary or appropriate for the diagnosis and care of the Member and otherwise in accordance with Section 5.5.1; or (ii) notification of participation status with other HMOs or insurers. This section shall continue to be in effect for a period of one (1) year after the expiration or termination of this Agreement.

8.0 DISPUTE RESOLUTION

8.1 Member Grievance Dispute Resolution.
Provider agrees to (a) cooperate with and participate in Company's applicable appeal, grievance and external review procedures (including, but not limited to, Medicare appeals and expedited appeals procedures), (b) provide Company with the information necessary to resolve same, and (c) abide by decisions of the applicable appeals, grievance and review committees.

8.2 Provider Dispute Resolution.
Company shall provide an internal mechanism whereby Provider may raise issues, concerns, controversies or claims regarding the obligations of the Parties under this Agreement. Provider shall exhaust this internal

mechanism prior to instituting any arbitration or other permitted legal proceeding. Discussions and negotiations held pursuant to this Section 8.2 shall be treated as inadmissible compromise and settlement negotiations for purposes of applicable rules of evidence.

8.3 Arbitration.

8.3.1 Submission of Claim or Controversy to Arbitration. Any controversy or claim arising out of or relating to this Agreement or the breach, termination, or validity thereof, except for temporary, preliminary, or permanent injunctive relief or any other form of equitable relief, shall be settled by binding arbitration. However, before any contractual or claim payment dispute proceeds to arbitration, Provider must have fully exhausted Company's internal provider dispute resolution processes. Upon mutual consent of the parties, the arbitration will be administered by the American Arbitration Association ("AAA") or the Judicial Arbitration and Mediation Services ("JAMS") and conducted by a sole Arbitrator. The arbitrator shall be, to the extent available, either a retired judge or selected from a panel of persons trained and expert in the area of health care law. Arbitration proceedings shall take place in the State of New York. The governing law provision of this Agreement shall apply to the arbitration proceeding, except to the extent Federal substantive law would apply to any claim. The arbitrator shall prepare in writing and provide to the parties an award including factual findings and the reasons on which their decision is based. If a party believes that the arbitrator has committed an error of law or legal reasoning, the party can appeal to a court of competent jurisdiction to correct any such error of law or legal reasoning. There is no right to de novo review of the arbitration decision. The decision of the arbitrator may be entered and enforced as a final judgment in any court of competent jurisdiction. A stenographic record shall be made of all testimony in any arbitration in which any disclosed claim or counterclaim exceeds $250,000. The Commissioner shall receive notice of issues going to arbitration as well as copies of decisions thereof. The New York Department of Health shall not be bound by the decision of the arbitrator.

8.3.2 Confidentiality. Except as may be required by law or to the extent necessary in connection with a judicial challenge, permitted appeal, or enforcement of an Award, neither a Party nor an arbitrator may disclose the existence, content, record, status or results of a negotiation or arbitration. Any information, document, or record (in whatever form preserved) referring to, discussing, or otherwise related to a negotiation or arbitration, or reflecting the existence, content, record, status, or results of a negotiation ("Negotiation Record") or arbitration ("Arbitration Record"), is confidential. The arbitration hearing shall be closed to any person or entity other than the arbitrator, the parties, witnesses during their testimony, and attorneys of record. Upon the request of a Party, an arbitrator may take such actions as are necessary to enforce this Section 8.3.2, including the imposition of sanctions.

8.3.3 Pre-hearing Procedure for Arbitration. The Parties will cooperate in good faith in the voluntary, prompt and informal exchange of all documents and information (that are neither privileged nor proprietary) relevant to the dispute or claim, all documents in their possession or control on which they rely in support of their positions or which they intend to introduce as exhibits at the hearing, the identities of all individuals with knowledge about the dispute or claim and a brief description of such knowledge, and the identities, qualifications and anticipated testimony of all experts who may be called upon to testify or whose report may be introduced at the hearing. The Parties and Arbitrator will make commercially reasonable efforts to conclude the document and information exchange process within sixty (60) calendar days after all pleadings or notices of claims have been received. At the request of a Party in any arbitration in which any disclosed claim or counterclaim exceeds $250,000.00, the Arbitrator may also order pre-hearing discovery by deposition upon good cause shown. Such depositions shall be limited to a maximum of three (3) per Party and shall be limited to a maximum of six (6) hours' duration each. As they become aware of new documents or information (including experts who may be called upon to testify), all Parties remain under a continuing obligation to provide relevant, non-privileged documents, to supplement their identification of witnesses and experts, and to honor any understandings between the Parties regarding documents or information to be exchanged. Documents that have not been previously exchanged, or witnesses and experts not

previously identified, will not be considered by the Arbitrator at the hearing. Fourteen (14) calendar days before the hearing, the Parties will exchange and provide to the Arbitrator (a) a list of witnesses they intend to call (including any experts) with a short description of the anticipated direct testimony of each witness and an estimate of the length thereof, and (b) premarked copies of all exhibits they intend to use at the hearing.

8.3.4 Arbitration Award. The arbitrator may award only monetary relief and is not empowered to award damages other than as set forth in this Agreement. The Award shall be in satisfaction of all claims by all Parties. Arbitrator fees and expenses shall be borne equally by the Parties. Postponement and cancellation fees and expenses shall be borne by the Party causing the postponement or cancellation. Fees and expenses incurred by a Party in successfully enforcing an Award shall be borne by the other Party. Except as otherwise provided in this Agreement, each Party shall bear all other fees and expenses it incurs, including all filing, witness, expert witness, transcript, and attorneys' fees.

8.3.5 Survival. The provisions of Section 8.3 shall survive expiration or termination of this Agreement, regardless of the cause giving rise hereto.

8.4 Arbitration Solely Between Parties; No Consolidation or Class Action.
Company and Provider agree that any arbitration or other proceeding related to a dispute arising under this Agreement shall be conducted solely between them. Neither Party shall request, nor consent to any request, that their dispute be joined or consolidated for any purpose, including without limitation any class action or similar procedural device, with any other proceeding between such Party and any third party.

9.0 MISCELLANEOUS

9.1 Amendments.
This Agreement constitutes the entire understanding of the Parties hereto and no changes, amendments or alterations shall be effective unless signed by both Parties, except as expressly provided herein. Notwithstanding the foregoing, at Company's discretion, Company may amend this Agreement upon written notice, by letter, newsletter, electronic mail or other media, to Provider to comply with applicable law or regulation, or any order or directive of any governmental agency. This Agreement shall be deemed to be automatically amended to conform with all laws and regulations promulgated at any time by any state or federal regulatory agency or authority of this Agreement. Any material amendment to this Agreement requires the prior approval of the New York State Department of Health thirty (30) days in advance of its anticipated execution.

9.2 Waiver.
The waiver by either Party of a breach or violation of any provision of this Agreement shall not operate as or be construed to be a waiver of any subsequent breach thereof. To be effective, all waivers must be in writing and signed by an authorized officer of the Party to be charged. Provider waives any claims or cause of action for fraud in the inducement or execution related hereto.

9.3 Governing Law.
This Agreement shall be governed in all respects by the laws of the State of New York.

9.4 Severability.
Any determination that any provision of this Agreement or any application thereof is invalid, illegal or unenforceable in any respect in any instance shall not affect the validity, legality and enforceability of such provision in any other instance, or the validity, legality or enforceability of any other provision of this Agreement. Neither Party shall assert or claim that this Agreement or any provision hereof is void or voidable if such Party performs under this Agreement without prompt and timely written objection.

9.5 Successors; Assignment.

This Agreement relates solely to the provision of Provider Services by Provider and does not apply to any other organization which succeeds to Provider assets, by merger, acquisition or otherwise, or is an affiliate of Provider. Neither Party may assign its rights or delegate its duties and obligations under this Agreement without the prior written consent of the other Party, which consent may not be unreasonably withheld; provided, however, that Company may assign its rights or delegate its duties and obligations to an Affiliate or successor in interest so long as any such assignment or delegation will not have a material impact upon the rights, duties and obligations of Provider.

9.6 Headings.
The headings contained in this Agreement are included for purposes of convenience only, and shall not affect in any way the meaning or interpretation of any of the terms or provisions of this Agreement.

9.7 Notices.
Except for any notice required under Article 6, Term and Termination, or if otherwise specified, notices required pursuant to the terms and provisions hereof may be effective if sent by letter, electronic mail or other generally accepted media. With respect to notices required under Article 6, notices shall be effective only if given in writing and sent by overnight delivery service with proof of receipt, or by certified mail return receipt requested. Notices shall be sent to the following addresses (which may be changed by giving notice in conformity with this Section 9.7). Provider shall notify Company of any changes in the information provided by Provider below.

To Provider at:

Warren County Public Health Services
1340 State Route 9
Lake George, NY 12845

and to Company at:

Aetna
Contract Consulting Unit
151 Farmington Avenue, RS2A
Hartford, CT 06156

9.8 Remedies.
Notwithstanding Sections 8.3 and 9.3, the Parties agree that each has the right to seek any and all remedies at law or equity in the event of breach or threatened breach of Section(s) 5.5, 6.6 and 7.3.

9.9 Non-Exclusivity.
This Agreement is not exclusive, and nothing herein shall preclude either Party from contracting with any other person or entity for any purpose. Company makes no representation or guarantee as to the number of Members who may select or be assigned to Provider.

9.10 Force Majeure.
If either Party shall be delayed or interrupted in the performance or completion of its obligations hereunder by any act, neglect or default of the other Party, or by an embargo, war, act of terror, riot, incendiary, fire, flood, earthquake, epidemic or other calamity, act of God or of the public enemy, governmental act (including, but not restricted to, any government priority, preference, requisition, allocation, interference, restraint or seizure, or the necessity of complying with any governmental order, directive, ruling or request) then the time of completion specified herein shall be extended for a period equivalent to the time lost as a result thereof. This Section 9.10 shall not apply to either Party's obligations to pay any amounts owing to the other Party, nor to any strike or labor dispute involving such Party or the other Party.

9.11 Survival.

In addition to those provisions which by their terms survive expiration or termination of this Agreement (e.g. 4.3.2 and 5.3.1), Sections 5.5, 6.5 and 7.3 shall survive expiration or termination of this Agreement, regardless of the cause giving rise thereto.

9.12 Entire Agreement.
This Agreement (including any attached schedules) constitutes the complete and sole contract between the Parties regarding the subject hereof and supersedes any and all prior or contemporaneous oral or written representations, communications, proposals or agreements not expressly included herein and may not be contradicted or varied by evidence of prior, contemporaneous or subsequent oral representations, communications, proposals, agreements, prior course of dealings or discussions of the Parties. There are no oral agreements between the Parties. Provider represents that it has not relied on any data, financial analysis, reports, notes, proposals, conclusions or projections, whether made orally or in writing, made by Company or any of its representatives, agents, employees or advisors, in connection with negotiation, acceptance, execution or delivery of the Agreement by Provider.

IN WITNESS WHEREOF, the undersigned parties have executed this Agreement by their duly authorized officers, intending to be legally bound hereby.

PROVIDER

By:

Printed Name:

Title:

Date:

FEDERAL TAX I.D. NUMBER:

COMPANY

By:

Printed Name:

Title:

Date:

Exhibit A – Company Affiliates List

Notwithstanding any other provision of this Agreement, none of the following entities shall be deemed to be a Company Affiliate for purposes of this Agreement when operating in the capacity of (i) a party to a state contract to provide services pursuant to a Medicaid program, or (ii) a downstream subcontractor providing all or a portion of such services.

Aetna Health of California Inc. (California)
Aetna Health Inc. (Connecticut)
Aetna Health Inc. (Florida)
Aetna Health Inc. (Georgia)
Aetna Health Inc. (Maine)
Aetna Health Inc. (New Jersey)
Aetna Health Inc. (New York)
Aetna Health Inc. (Pennsylvania)
Aetna Health Inc. (Texas)
Aetna Dental of California Inc. (California)
Aetna Dental Inc. (New Jersey)
Aetna Dental Inc. (Texas)
Aetna Rx Home Delivery, LLC (Delaware)
Aetna Health Management, LLC (Delaware)
Aetna Ireland, LLC (Delaware)
Chickering Claims Administrators, Inc. (Massachusetts)
Aetna Specialty Pharmacy, LLC (Delaware)
Cofinity, Inc. (Delaware)
Aetna Student Health Agency Inc. (Massachusetts)
Aetna Life Insurance Company (Connecticut)
Aetna Behavioral Health of Delaware, LLC (Delaware)
Aetna Workers' Comp Access, LLC (Delaware)
Aetna Behavioral Health, LLC (Delaware)
Aetna Health and Life Insurance Company (Connecticut)
Aetna Health Insurance Company (Pennsylvania)
Aetna Health Insurance Company of New York (New York)
Aetna Life & Casualty (Bermuda) Ltd. (Bermuda)
Aetna Health Services (UK) Limited (England & Wales)
Aetna Global Benefits (Bermuda) Limited (Bermuda)
Goodhealth Worldwide (Global) Limited (Bermuda)
Aetna Global Benefits (Europe) Limited (England & Wales)
Aetna Global Benefits (Asia Pacific) Limited (Hong Kong)
Goodhealth Worldwide (Asia) Limited (Hong Kong)
Aetna Global Benefits Limited (DIFC, UAE)
Aetna Health Services (Middle East) FZ-LLC (DOZ-UAE)
Aetna Health Insurance Company of Europe Limited (Ireland)
Aetna (Shanghai) Enterprise Services Co. Ltd. (China)
Aetna Global Benefits Administrators Inc. (Florida)
Aetna Global Benefits (Singapore) PTE. Ltd.
Prodigy Health Group Holdings, Inc. (Delaware)
Prodigy Health Group, Inc. (Delaware)
American Health Holdings, Inc. (Ohio)
Meritain Health, Inc. (New York)
Prime Net, Inc. (Ohio)
American Continental Insurance Company
Continental Life Insurance Company of Brentwood Tennessee
Aetna Insurance (Singapore) Pte. Ltd.
Innovation Health Plan, Inc.
Innovation Health Insurance Company

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

March 1, 2011

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:
   - quality improvement/management;
   - utilization management, including but not limited to precertification procedures, referral process or protocols, and reporting of clinical encounter data;
   - member grievances; and
   - 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 B 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 other 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.

APPENDIX B
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 any 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:

PRODUCT PARTICIPATION SCHEDULE

Participation under this Ancillary Agreement will include the Aetna Products indicated below. Compensation for these products will be according to the Services and Compensation Schedule attached to this Agreement.

- Gated Health Benefit Product – Commercial health benefit plan which contains a Primary Care Physician as a component of the Plan design regardless of whether (i) selection of a Primary Care Physician is mandatory or voluntary under the terms of the Plan; or, (ii) an individual Member has selected a Primary Care Physician. Gated Health Benefit Products include but are not limited to: *HMO, QPOS, Elect Choice, Managed Choice POS, Aetna Choice POS II, and Aetna Select.*

- Non-Gated Health Benefit Product – Commercial health benefit plan which does not allow for the designation and/or use of a Primary Care Physician in the administration of the benefit Plan. Non-Gated Health Benefit Products include but are not limited to: *Open Choice PPO and National Advantage.*

  Many member ID cards include the National Advantage logo (NAP) in conjunction with Gated and non-Gated Health Benefit Products. In those circumstances the rate applicable to other product (not NAP) on the ID card will apply.

- Government Programs – All plans offered by Company under any government contract serving Medicare beneficiaries. Government Programs include, but are not limited to: all Aetna Medicare Advantage HMO, PPO, and POS.

  Government Programs excludes Medicaid program offered by Company.

  Compensation for Government Programs may vary based upon the applicable products as specified in the Service and Compensation Schedule.

- Non-Health Benefit Products – Non Health Benefit products may apply to this contract in accordance with terms outlined in the Product Participation section of the agreement.

ANCILLARY SERVICES PROVIDER ("PROVIDER")
CORE PARTICIPATION CRITERIA SCHEDULE

I. BUSINESS CRITERIA

These criteria shall apply to each Provider for the duration of the Agreement and shall be enforced at the sole discretion of Company. Any exceptions to the Business Criteria must be approved in advance by the Company.

A. Applicability

1. If applicable, each Provider must complete a Facility Credentialing Questionnaire and shall periodically supply to Company all requested information.

B. Office Standards (applies to Providers that have an office setting)

Each Provider's office must:

1. Have a visible sign and title identifying the names of all providers practicing in the office.
2. Have all areas physically accessible to all Members, including, but not limited to its entrance, parking and bathroom facilities.
3. Have a clean, properly equipped and accessible patient toilet and hand washing facility.
4. Have a waiting room sufficient to accommodate Members.
5. Have At least two (2) examining rooms which are clean, properly equipped and private.
6. Have an office assistant in office during scheduled hours.
7. Require a medical assistant to attend sensitive (e.g., gynecological) examinations, unless the Member declines such assistant to be present.
8. If vaccines are stored, keep a thermometer in the refrigerator and freezer.
9. Have appropriate protocol immediately available for the treatment of medical emergencies and must have documented medical emergencies procedures addressing treatment, transportation and disaster evacuation plans to provide for the safety of Members. Additionally, office/business must have functional generators to provide emergency power service in the event of a power failure, when appropriate, e.g., offices that perform procedures, store biologics or supplies of vaccines.

C. Business Standards

Each Provider's business must:

1. Be clean, presentable and professional in appearance and prohibit smoking.
2. If providing controlled substances, maintain them in a secure and concealed location.
3. Have a secure and confidential filing system.
4. Have written policies protecting Member confidentiality including medical records and maintain verbal and electronic means for submission of information.

5. Have an established process to ensure that medical records are protected from public access.

6. Have written policies addressing documentation about Advance Directives (whether executed or not) in member's record (except for under age 18).

7. Have written policies addressing office anti-discrimination guidelines.

8. Comply with Company's then current policies and all applicable legal requirements regarding use of allied health professionals.

9. Maintain evidence of current licenses for all Providers practicing, including: state professional license, Federal Drug Enforcement Agency and State Controlled Drug Substance (where applicable).

10. Keep on file and make available to Company any state required practice protocols or supervising agreements for Allied Health Professionals practicing.

11. Designate by age, according to Company guidelines, those Members for whom provider will provide care.

D. Access and Availability of Services

If applicable, each Provider's office/business must:

1. Must offer a reliable mechanism for Members and other health care professionals to be reached twenty-four (24) hours a day, seven (7) days a week.

2. Shall ensure that twenty-four (24) hours a day, seven (7) days a week coverage for Members is rendered by Provider or arranged with another Company Participating Provider.

3. For outpatient services, a covering Provider's office must be geographically accessible and consistent with local community patterns of care to help ensure that a Member is not required to travel more than thirty (30) minutes travel time from the Member's regular Provider's office/business to access the covering Provider's services.

4. For Aetna Workers' Comp Access (AWCA) when applicable, Provider shall schedule an initial visit and provide services within a reasonable period of time or, where applicable, within that period of time as required by workers compensation law.

E. Subcontractors

To the extent the Provider intends to subcontract some of its services under the Agreement, Provider will provide Company with a list of all subcontractors intended to be used to provide Provider Services to Members. In all circumstances, where Provider subcontracts for any services under the Agreement:

1. Provider represents and warrants that subcontractor(s) will abide by the provisions set forth in the Agreement; and

2. Company reserves the right to require a Designation of Payment Schedule from all subcontractors in a form approved by the Company. Provider shall indemnify and hold Company and its Members harmless for payment of all compensation owed subcontractor for services provider under the Agreement.

3. Company's prior written approval is required, if the Provider intends to perform covered services through employees or agents, including a subcontractor, if physically located outside of the United States of America.

F. Copies

Unless allowed by state law or regulatory requirement, Provider agrees not to charge Members for copies of medical records/reports or require deposits for the release of these copies to Members.

HOME HEALTH
ADDITIONAL PARTICIPATION CRITERIA

A. Provider Standards

1. Must have services that meet Company's approved accreditation agency standards which may include services of each of the following: Registered Nurses, Licensed Practical Nurses, Physical Therapists, Occupational Therapists, Registered Dietician and a Pharmacist on consult.

2. Home Health Agency's primary location must be either accredited or Centers for Medicare and Medicaid Services (CMS) certified. If the Home Health Agency moves the primary location, a new accreditation or CMS certification must be obtained.

3. Each additional branch must be included in the primary location's accreditation or CMS certification.

B. Provider Requirements

1. Must educate patients in self-care techniques and home care management, including, but not limited to, providing written Member education materials.

2. Must maintain adequate staff to meet the needs of Members.

3. Upon request by Company if Provider conducts patient satisfaction surveys, survey responses shall be made available to Company at the same time and with the same frequency.

4. Services provided by an employee to a household member or his/her spouse's family member is not a covered expense.

C. Access and Availability of Services

1. Provider must have availability of Provider's registered nursing staff twenty-four (24) hours a day, seven (7) days a week. Other clinical staff must be available Monday through Friday, 8:00 a.m. to 5:00 p.m.

2. Provider must be able to initiate a therapy within three (3) hours of the referral call for urgent services and within twenty-four (24) hours of the referral call for routine services.

HOME HEALTH CARE SERVICE
COMPENSATION SCHEDULE

COMPENSATION:

Payment Details:

Service	Billing Codes	Rates
Services of skilled nurse in home health setting (Each 15 minutes)	**HCPC Codes:** G0154	$97.00 Per Visit
Nursing Care, in the home; by registered nurse	**HCPC Codes:** S9123	$85.00 Per Hour
Nursing Care, in the home; by licensed practical nurse	**HCPC Codes:** S9124	$35.00 Per Hour
Services of Home Health Aide in Home Health Setting, each 15 minutes	**HCPC Codes:** G0156	$40.00 Per Visit
Home Health Aide	**HCPC Codes:** S9122	$20.00 Per Hour
Services of physical therapist in home health setting, each 15 minutes	**HCPC Codes:** G0151	$97.00 Per Visit
Services of occupational therapist in home health setting, each 15 minutes	**HCPC Codes:** G0152	$97.00 Per Visit
Services of speech and language pathologist in home health setting, each 15 minutes	**HCPC Codes:** G0153	$97.00 Per Visit
Services of clinical social worker in home health setting, each 15 minutes	**HCPC Codes:** G0155	$97.00 Per Visit
All Other Outpatient		100% of Aetna Market Fee Schedule

COMPENSATION TERMS AND CONDITIONS:

Services

Services provided by Home Health Agency will include:

- 24 hour STAT ability
- Nurse on-call 24 hours
- Draw blood for lab tests
- Deliver and pick-up of lab test and inform primary care physician of lab results
- Instruction of member and/or caregiver

Definitions

"Aetna Market Fee Schedule" (AMFS) – A fee schedule that is based upon the contracted location where service is performed.

"Service Groupings" – A grouping of codes (e.g., HCPCS, CPT4, ICD-9 (ICD-10 or successor standard)) that are considered similar services and are contracted at one rate under the Services and Compensation Schedule.

General

a) Rates are inclusive of any applicable Member Copayment, Coinsurance, Deductible and any applicable tax, including but not limited to sales tax. For procedures and/or services not specifically listed above, Provider agrees to accept then current AMFS as payment in full. No additional charges are allowed regardless of the time spent at the Member's home, for travel, administrative services, miscellaneous supplies, weekend, evening or holiday differentials. Company will pay the lesser of the contracted rate or eligible billed charges.

b) Hourly rates, for nursing care/home health aides are not to be used for visits expected to be two hours or less in duration. These rates apply to extended periods of service, (shift care greater than 2 hours in duration) when authorized by Company. Codes S9123 and S9124 are to be utilized for nursing care related to skilled nursing visits and S9122 for home health aide hourly visits.

c) The above payment rate for a skilled nursing visit (G0154) and a home health aide (G0156) shall include from one (1) to a maximum of eight (8) fifteen (15) minute units of service of a skilled nurse or home health aide in a home health setting. Units billed in excess of eight (8) are not payable under the visit rate unless specifically authorized. If more than one visit of a skilled nurse or home health aide is authorized per day under code G0154 or G0156, Provider will be paid in accordance with the number of visits authorized per day.

d) The payment rate for a physical therapist, occupational therapist, speech and language pathologist or clinical social worker visit shall be limited to one times the visit rate per date of service regardless of the number of units billed.

e) Provider must utilize Aetna authorized laboratory for all clinical lab work.

f) Post natal assessment and follow up care (99501) rate is inclusive of both mother and baby(ies). Home visit for newborn care and assessment (99502) rate is not payable in conjunction with code 99501.

g) Except where prohibited by applicable law of the Agreement, Company may, at its sole discretion, upon thirty (30) days prior written notice to Provider reduce the rates for Covered Services by ten percent (10%) for a three (3) month period should Provider fail to provide timely notice of change in information to Company as set forth in the Agreement.

Billing

h) Provider must designate the codes set forth in this Compensation Schedule when billing, and provide the number of units of service provided.

i) When Provider is compensated on a fee for services basis and if a Government Official imposes a financial adjustment or penalty on Company based on a determination that there is insufficient information or documentation to support an International Classification of Diseases, 9th Revision, Clinical Modification ("ICD-9-CM" (ICD-10 or successor standard)) diagnosis submitted by Provider to Company for a Medicare

Member ("Diagnosis"), Company may recoup an amount that Company paid to Provider for the nationally recognized codes associated with the Diagnosis for the dates of service in question, for which that Diagnosis was listed. Company will notify Provider upon Company's receipt of a final written audit report from CMS reflecting a CMS finding that there was insufficient documentation to support a Diagnosis submitted by Provider to Company ("CMS Finding"). Company will provide a copy of the chart for which the Diagnosis was listed and reviewed by CMS and recoup from Provider an amount that Company paid to Provider for the nationally recognized codes associated with the Diagnosis for the dates of service in question, for which that Diagnosis was listed.

Coding

j) Company utilizes nationally recognized coding structures including, but not limited to, Revenue Codes as described by the Uniform Billing Code, AMA Current Procedural Terminology (CPT4), CMS Common Procedure Coding System (HCPCS), Diagnosis Related Groups (DRG), ICD-9 (ICD-10 or successor standard) Diagnosis and Procedure codes, National Drug Codes (NDC) and the American Society of Anesthesiologists (ASA) relative values for the basic coding, and description for the services provided. As changes are made to nationally recognized codes, Company will update internal systems to accommodate new codes. Such updates may include changes to Service Groupings. Such changes will only be made when there is no material change in the procedure itself. Until updates are complete, the procedure will be paid according to the standards and coding set for the prior period.

Company will comply and utilize nationally recognized coding structures as directed under applicable Federal laws and regulations, including, without limitation, the Health Insurance Portability and Accountability Act (HIPAA).

Service and Pay to (Remittance) Location Form

Listed below is each participating provider* with the corresponding physical service location, pay to (remittance) address and telephone numbers:

***Upon written notice from Provider, Company may agree to add new or relocating facilities, locations or providers to existing Agreement upon completion of applicable credentialing and satisfaction of all other requirements of Company. Other demographic information may be revised upon written notice from Provider.**

Provider Name: _____Warren County Public Health Services_____

Service Location Name		Pay to (Remittance) Name	
Warren County Public Health Services		Electronic Pay to (Remittance) Name *(as it appears on the submission)*	Warren County Public Health Services
Street	1340 SR 9	Address	1340 SR 9
Suite #		Suite #	
City	Lake George	City	Lake George
State, Zip	NY 12845	State, Zip	NY 12845
Phone #	518-761-6415	Phone #	518-761-6415
Fax #	518-761-6562	Fax #	518-761-6562
Email Address		Email Address	
Tax ID #	146002576	NPI:	NPI Type: 2

Company Use Only: **PIN # __5625297_____** **PVN # _____**

Service Location Name		Pay to (Remittance) Name	
		Electronic Pay to (Remittance) Name *(as it appears on the submission)*	
Street		Address	
Suite #		Suite #	
City		City	
State, Zip		State, Zip	
Phone #		Phone #	
Fax #		Fax #	
Email Address		Email Address	
Tax ID #		NPI:	NPI Type:

Company Use Only: **PIN # _____** **PVN # _____**

RESOLUTION REQUEST FORM NO. 20

MISCELLANEOUS*

***Please List All Other Requests Not Covered by Previous Resolution Request Forms Here. Please attach any backup information available and be as detailed as possible.**

DEPARTMENT NAME: Health Services

DATE: 04/26/13

(a) Purpose of Request: To authorize the Health Services Department to participate in the Americares US Partnerships to allow receipt of specific vaccines as offered.

(b) Details: An administration fee would be charged to the individual patient but not charge for the vaccine. There would be not cost to the county to participate in this program.

(c) Previous Resolution Number: Not applicable and would allow individuals not covered by insurance to receive vaccines with only an administrative fee.

Stern, Helen

From: AmeriCares US Partnerships [USPartnerships@americares.org]
Sent: Tuesday, March 26, 2013 10:53 AM
To: Stern, Helen
Subject: Your AmeriCares Clinics username

Hello,

A username reminder has been requested for your AmeriCares Clinics account.

Your username is HPSTERN.

Your password is 321DENVER.

To login to your account, click on the link below.

http://usaccess.americares.org/clinics/index.php?option=com_user&view=login

Thank you.

Basic Information | Ship To Address | Medical Contact | Key Staff | Clinic Information | Pharmacy Information | Submit Application

Basic Organization Information

Organization Name*	Warren County Public Health
EIN*	146002576
Hours of Operation*	8-4 EST

Designated Primary Contact

Name*	Helen Stern
Title*	Immunization Coordinator
Phone*	518 761 6580
Fax:	518 761 6422
Email*	sternh@warrencountyny.gov

Street Address

Address Line 1*	1340 State Route 9
Address Line 2:	
City*	Lake George
State*	NY
Zip*	12845

☑ Shipping Address same as above ?

*Required

Save & Continue

- AmeriCares (http:\\www.americares.org)
- Contact Info (/clinics/index.php?option=com_content&view=article&id=5&Itemid=31)
- Help (/clinics/index.php?option=com_content&view=article&id=12&Itemid=33)
- Log Out (/clinics/index.php?option=com_user&view=login&Itemid=34)

- Home (http://usaccess.americares.org/clinics/)
- Search (/clinics/index.php?option=com_wrapper&view=wrapper&Itemid=24)
- Orders (/clinics/index.php?option=com_wrapper&view=wrapper&Itemid=35)
- Needs List (/clinics/index.php?option=com_wrapper&view=wrapper&Itemid=39)
- View Application (/clinics/index.php?option=com_wrapper&view=wrapper&Itemid=40)
- Newsroom (/clinics/index.php?option=com_wrapper&view=wrapper&Itemid=41)
  - Edit Account Info (/clinics/index.php?option=com_user&view=user&layout=form&Itemid=50)

Home

Basic Information | Ship To Address | Medical Contact | Key Staff | Clinic Information | Pharmacy Information | Submit Application

Ship To Address

Address Line 1*	1340 State Route 9
Address Line 2:	
City*	Lake George
State*	NY
Zip*	12845

*Required

Back Save & Continue

- AmeriCares (http:\\www.americares.org)
- Contact Info (/clinics/index.php?option=com_content&view=article&id=5&Itemid=31)
- Help (/clinics/index.php?option=com_content&view=article&id=12&Itemid=33)
- Log Out (/clinics/index.php?option=com_user&view=login&Itemid=34)

- Home (http://usaccess.americares.org/clinics/)
- Search (/clinics/index.php?option=com_wrapper&view=wrapper&Itemid=24)
- Orders (/clinics/index.php?option=com_wrapper&view=wrapper&Itemid=35)
- Needs List (/clinics/index.php?option=com_wrapper&view=wrapper&Itemid=39)
- View Last Application (/clinics/index.php?option=com_wrapper&view=wrapper&Itemid=40)
- Newsroom (/clinics/index.php?option=com_wrapper&view=wrapper&Itemid=41)
  - Edit Account Info (/clinics/index.php?option=com_user&view=user&layout=form&Itemid=50)

Home

Create an account → 2 Complete application → Get approved → Choose available products

Basic Information | Ship To Address | Medical Contact | Key Staff | Clinic Information | Pharmacy Information | Submit Application

Primary Medical Contact

Name*	Dr. Dan Larson
Phone*	518-761-0300
Fax:	
Email*	dlarson@hhhn.org
Position in Organization*	Medical Director
License Type*	Medical
Describe Specialty*	Practitioner
State Licensed*	NY
License #*	138120-1
Expiration Date*	06/30/2014 (MM/DD/YYYY)

*Required

Back | Save & Continue

- AmeriCares (http:\\www.americares.org)
- Contact Info (/clinics/index.php?option=com_content&view=article&id=5&Itemid=31)
- Help (/clinics/index.php?option=com_content&view=article&id=12&Itemid=33)
- Log Out (/clinics/index.php?option=com_user&view=login&Itemid=34)

- Home (http://usaccess.americares.org/clinics/)
- Search (/clinics/index.php?option=com_wrapper&view=wrapper&Itemid=24)
- Orders (/clinics/index.php?option=com_wrapper&view=wrapper&Itemid=35)
- Needs List (/clinics/index.php?option=com_wrapper&view=wrapper&Itemid=39)
- View Application (/clinics/index.php?option=com_wrapper&view=wrapper&Itemid=40)
- Newsroom (/clinics/index.php?option=com_wrapper&view=wrapper&Itemid=41)
  - Edit Account Info (/clinics/index.php?option=com_user&view=user&layout=form&Itemid=50)

Home

Basic Information | Ship To Address | Medical Contact | Key Staff | Clinic Information | Pharmacy Information | Submit Application

Key Staff

Executive Director

Name* Patricia Auer

Phone* 518-761-6571

Email* auerp@warrencountyny.gov

Administrative Director

Name:

Phone:

Email:

Pharmaceutical Director

Name:

Phone:

Email:

*Required

Back Save & Continue


Create an account

Complete application

Get approved

Choose available products

Basic Information | Ship To Address | Medical Contact | Key Staff | Clinic Information | Pharmacy Information | Submit Application

Organization Information

Organization Type*	Select Type			
Services Provided*	☐ Primary Care	☐ Secondary Care	☐ HIV/AIDS	☐ Arthritis
	☐ Respiratory	☐ Diabetic	☐ Mental Health	☐ Womans
	☐ Cardiac	☐ Cholesterol	☐ Dental	☑ Other

Annual Unduplicated Patients*	2500
Annual Patient Visits*	2000

Budget Info

Total Annual Operating Budget*	$399133.
Pharmaceutical Procurement Budget*	$85000
Source of Funding*	public taxes
Will your organization*	☑ Distribute AmeriCares products free of charge ?
# Volunteers	n/a
# With Medical Qualifications	n/a
# FT Staff	4
# With Medical Qualifications	4
# PT Staff	6
# With Medical Qualifications	6
Please describe any disaster	we have held emergency preparedness practice

response programs:

*Required Back Save & Continue

- AmeriCares (http:\\www.americares.org)
- Contact Info (/clinics/index.php?option=com_content&view=article&id=5&Itemid=31)
- Help (/clinics/index.php?option=com_content&view=article&id=12&Itemid=33)
- Log Out (/clinics/index.php?option=com_user&view=login&Itemid=34)

- Home (http://usaccess.americares.org/clinics/)
- Search (/clinics/index.php?option=com_wrapper&view=wrapper&Itemid=24)
- Orders (/clinics/index.php?option=com_wrapper&view=wrapper&Itemid=35)
- Needs List (/clinics/index.php?option=com_wrapper&view=wrapper&Itemid=39)
- View Application (/clinics/index.php?option=com_wrapper&view=wrapper&Itemid=40)
- Newsroom (/clinics/index.php?option=com_wrapper&view=wrapper&Itemid=41)
  - Edit Account Info (/clinics/index.php?option=com_user&view=user&layout=form&Itemid=50)

Home

Create an account | 2 Complete application | Get approved | Choose available products

Basic Information | Ship To Address | Medical Contact | Key Staff | Clinic Information

insured payments private pay

Organization Information

Organization Type* Public Health Dept

Services Provided*
- ☐ Primary Care ☐ Secondary Ca
- ☐ Respiratory ☐ Diabetic
- ☐ Cardiac ☐ Cholesterol ☐ Dental

Annual Unduplicated Patients* 2500

Annual Patient Visits* 2000

Budget Info

Total Annual Operating Budget* $399133.

Pharmaceutical Procurement Budget* $85000

Source of Funding* public taxes

Will your organization* ☐ Distribute AmeriCares products free of charge ?

Volunteers n/a

With Medical Qualifications n/a

FT Staff 4

With Medical Qualifications 4

PT Staff 6

With Medical Qualifications 6

Please describe any disaster we have held emergency preparedness practice

response programs:

*Required Back Save & Continue

- AmeriCares (http:\\www.americares.org)
- Contact Info (/clinics/index.php?option=com_content&view=article&id=5&Itemid=31)
- Help (/clinics/index.php?option=com_content&view=article&id=12&Itemid=33)
- Log Out (/clinics/index.php?option=com_user&view=login&Itemid=34)

- Home (http://usaccess.americares.org/clinics/)
- Search (/clinics/index.php?option=com_wrapper&view=wrapper&Itemid=24)
- Orders (/clinics/index.php?option=com_wrapper&view=wrapper&Itemid=35)
- Needs List (/clinics/index.php?option=com_wrapper&view=wrapper&Itemid=39)
- View Application (/clinics/index.php?option=com_wrapper&view=wrapper&Itemid=40)
- Newsroom (/clinics/index.php?option=com_wrapper&view=wrapper&Itemid=41)
  - Edit Account Info (/clinics/index.php?option=com_user&view=user&layout=form&Itemid=50)

Home

Basic Information | Ship To Address | Medical Contact | Key Staff | Clinic Information | Pharmacy Information | Submit Application

Pharmacy Info

- ☐ Are you a licensed pharmacy ?
- ☐ Do you have a dispensing certificate ?
- ☑ Are licensed physicians involved in receiving/dispensing prescription medications ?
- ☑ Do you track which patients have received products by lot number ?
- ☑ Can you ensure that medications will be stored properly ?
- ☑ Do you have refrigeration available for medications ?
- ☑ Do you have Climate Control ?

Please describe security available for your pharmaceuticals*: the vaccines are kept in the refrigerator. The temperatures are monitored twice daily. The refrigerator is located in a locked room.

Please describe destruction protocols for expired product*: expired vaccine is disposed of in the toxic waste container.

Who dispenses medications* Nurse ☐

Please select all information currently being tracked in your pharmaceutical inventory system*

☑ Donor/Vendor	☑ Date of Receipt	☑ Brand Name	☐ Generic
☑ Quantity	☑ Formulation	☑ NDC Number	☑ Manufacturer
☑ Lot	☑ Expiration	☑ Distribution Date	☑ Patient Information

*Required Back Save & Continue

- AmeriCares (http:\\www.americares.org)
- Contact Info (/clinics/index.php?option=com_content&view=article&id=5&Itemid=31)
- Help (/clinics/index.php?option=com_content&view=article&id=12&Itemid=33)
- Log Out (/clinics/index.php?option=com_user&view=login&Itemid=34)

- Home (http://usaccess.americares.org/clinics/)
- Search (/clinics/index.php?option=com_wrapper&view=wrapper&Itemid=24)
- Orders (/clinics/index.php?option=com_wrapper&view=wrapper&Itemid=35)
- Needs List (/clinics/index.php?option=com_wrapper&view=wrapper&Itemid=39)
- View Application (/clinics/index.php?option=com_wrapper&view=wrapper&Itemid=40)
- Newsroom (/clinics/index.php?option=com_wrapper&view=wrapper&Itemid=41)
  - Edit Account Info (/clinics/index.php?option=com_user&view=user&layout=form&Itemid=50)

Home

Create an account → Complete application → 3 Get approved → Choose available products

Basic Information | Ship To Address | Medical Contact | Key Staff | Clinic Information | Pharmacy Information | Submit Application

Agreement

Please read the following terms and conditions:

MEDICAL PROFESSIONAL AGREEMENT OF RESPONSIBILTY 2012

This form is to be completed by organizations receiving medical products through AmeriCares' Global Medical Assistance Program, and must include the physician's signature and current license number (or relevant medical documentation/certification).

This document is to certify that (name of medical professional) Dan Larson works on behalf of (name of organization) WCHS in (city/state) and is licensed to prescribe medicine.

☐ I verify that I am the designated medical professional for the organization and that I have read and agree to the terms and conditions of the "Medical Professional Agreement of Responsibility"

GLOBAL MEDICAL ASSISTANCE
UNITED STATES AFFILIATE PARTNERSHIP AGREEMENT
2012

I. Purpose

The purpose of this agreement between AmeriCares Foundation, Inc. referred to as "AmeriCares" and Affiliate Name (referred to as "Affiliate") is to establish terms and guidelines for receiving, distributing and/or dispensing gift-in-kind donations through the AmeriCares Global Medical Assistance Program (GMA). The GMA Program aims to deliver high quality medical products—free of charge—to organizations and health care institutions serving vulnerable and underserved populations around the globe.

☐ I verify that I have read and agree to the terms and conditions to the "Global Medical Assistance United States Affiliate Partnership Agreement" and that I have the authority to bind the organization

Back Save & Submit Application

GLOBAL MEDICAL ASSISTANCE
UNITED STATES AFFILIATE PARTNERSHIP AGREEMENT
2012

I. Purpose

The purpose of this agreement between AmeriCares Foundation, Inc. referred to as "AmeriCares" and Affiliate Name (referred to as "Affiliate") is to establish terms and guidelines for receiving, distributing and/or dispensing gift-in-kind donations through the AmeriCares Global Medical Assistance Program (GMA). The GMA Program aims to deliver high quality medical products—free of charge—to organizations and health care institutions serving vulnerable and underserved populations around the globe.

II. Agreement Period

Upon signature, this Affiliate Agreement will cover the year following agreement date (365 days). Thereafter, this agreement may be extended upon mutual agreement. It will be reviewed by both parties periodically to ensure fulfillment of its purpose and to make any necessary additions and revisions.

III. Guiding Principles

AmeriCares and the Affiliate agree to work together to reduce suffering, restore health and save lives; our partnership leverages our respective core strengths, competencies and resources. In this collaborative endeavor, we agree to uphold the following guiding principles:

1. Place the interests of our beneficiaries first.
2. Respect local decision making and authority.
3. Maintain high organizational standards as humanitarian institutions.
4. Abide by laws and regulations that govern our work.
5. Protect the interests of our donors, our partners and stakeholders

IV. AmeriCares Roles & Responsibilities

Origin and Characteristics of GMA Donations

1. AmeriCares only accepts items from reliable sources, such as manufacturers and licensed wholesale distributors. Prior to receipt by AmeriCares, all offers of medical items are reviewed by the AC Medical Director and Pharmacist to ensure compliance with GMA Program standards and objectives.
2. AmeriCares warehouses are fully licensed and equipped to meet storage requirements for medical items.
3. AmeriCares will make every effort to ensure that information on donations provided to the Affiliate is accurate, complete and provided in a timely manner.
4. AmeriCares will notify the Affiliate of any unusual characteristics relating to an offer of gift-in-kind donations, including, but not limited to: bulk packaging, cold chain requirements, special usage considerations, donor restrictions, etc.

Distributing GMA Donations

5. AmeriCares will only ship items that have been reviewed and formally accepted by the Affiliate through the US Product Offer or the Web-based CRM system. AmeriCares will outline available product on its web-based CRM system. The Affiliate will select donated product appropriate for their operations and submit this list to AmeriCares by submitting their shopping cart. Upon submittal of a shopping cart, AmeriCares will make every attempt to fulfill the items requested in the shopping cart. AmeriCares will notify Affiliate of any items that cannot be provided.

6. AmeriCares will—in a timely manner—provide the Affiliate with all documents necessary for shipment.

7. AmeriCares agrees to notify the Affiliate immediately of any occurrence that has the potential to negatively impact the Affiliate, the Affiliate's beneficiaries and/or recipient organizations. Examples of such occurrences may be: product quality concerns or recalls; shipping delays; or legal claims made against AmeriCares in relation to the activities of this agreement. AmeriCares will work with the Affiliate to resolve and prevent future re-occurrence of such situations.

8. AmeriCares will investigate instances of missing, damaged and/or tampered-with products, based on Affiliate notification to AmeriCares at the time of receipt by completing the Detailed Confirmation of Receipt form.

Monitoring & Oversight

9. AmeriCares reserves the right to inspect all locations where the Affiliate stores and administers AmeriCares donations.

10. AmeriCares reserves the right to be involved in all phases of this partnership, including on-site visits to program activities, periodic implementation meetings and other measures necessary to monitor activities under this Agreement. AmeriCares will provide a minimum of two weeks prior notification whenever possible prior to any site visit.

11. AmeriCares reserves the right to audit (either directly or through a third party audit firm) the Affiliate's activities related to the implementation of these partnership activities, to ensure compliance with this agreement.

V. Partner's Roles & Responsibilities

Use of Gift-in-Kind Donations

1. Affiliate certifies that it will distribute and dispense GMA donations free of charge to people in need and will not require or solicit monetary payment or other items of value from institutions or individuals in association with the distribution of donations originating from AmeriCares.

2. Affiliate agrees to make every effort to utilize AmeriCares donations prior to date of expiry and to destroy any and all expired items in accordance with local waste disposal regulations and laws, notifying AmeriCares in advance of disposal plans. Affiliate will not distribute or dispense expired products or any products deemed substandard or of questionable quality.

3. Product destruction costs will be the responsibility of the Affiliate if the Affiliate is not able to utilize an AmeriCares donation(s) prior to their expiration date. In the event that the Affiliate has been informed of an AmeriCares Product Recall, or if AmeriCares shipped more than a Affiliate approved, AmeriCares will reimburse the Partner for the cost of destruction, if necessary.

Organizational Capacity

4. Affiliate will provide AmeriCares with proof of its status as a U.S. not-for-profit, charitable, public or government organization or other not-for-profit entity.

5. Upon request by AmeriCares, the Affiliate agrees to provide AmeriCares with additional information on the Affiliate organization, including, but not limited to: annual audited financial statements; copies of licenses and permits pertinent to the implementation of these partnership activities; and, names of Board of Directors members and key staff.

6. Affiliate will have adequate facilities, organizational capacity, and legal authorization to properly store, distribute and dispense all items in the volumes requested

7. Affiliate will have inventory management procedures that maintain supply chain integrity and track the distribution and usage of products, including procedures for: receiving stock; dispatching stock; periodic physical inventory counts; handling discrepancies between stock records and inventory; disposal of expired or unusable stock; record keeping controls; and reporting, etc. AmeriCares and the Affiliate may discuss throughout the agreement period ways in which to strengthen controls or improve inventory management practices.

8. Affiliate will assign responsibility for managing product donation offers from AmeriCares to a staff member (paid/volunteer or consultant) and designate one person to serve as a primary point of contact for AmeriCares. In order to ensure adequate communications capabilities needed for the success of this partnership, the Affiliate will provide its primary point of contact with regular access to a telephone, internet, and email.

Helen? Patty?

9. Affiliate will have a licensed physician, pharmacist, nurse or other qualified medical practitioner on staff, on board of directors or as a consultant (paid or volunteer). This medical professional will review each product donation offer or the shopping cart on the AmeriCares web-based CRM system before it is submitted, and will determine the appropriateness and usability of the items in the volumes requested. This medical professional will be duly licensed in the US State where the affiliate is located.

Donations Offers and Acceptances

10. AmeriCares will only ship items that have been formally accepted by the Affiliate, through the AmeriCares US product offer or the web-based CRM system.

11. Affiliate agrees that upon creation of a shopping cart, a qualified medical professional(s) will review all offered items and submit a response to AmeriCares within forty-eight (48) hours via the web-based CRM system.

Logistics

12.

13. Affiliate will immediately notify AmeriCares in the event any items on the packing list are missing or appear to have been damaged or tampered with during shipping. This information will be documented via the Detailed Confirmation of Receipt form.

14. Affiliate will not distribute products that appear to have been damaged, tampered with, or deemed substandard or of questionable quality in any other way.

Notification and Reporting

15. Affiliate agrees to notify AmeriCares immediately of any occurrence that has the potential to negatively impact this agreement's stakeholders, including Affiliate's beneficiaries AmeriCares and/or AmeriCares donors. Examples of such occurrences may be: unusual adverse reactions in patients who have received AmeriCares donated products; product quality concerns; shipment delays; or legal claims made against the Affiliate in relation to the activities of this partnership.

16. Affiliate agrees to meet AmeriCares reporting requirements which include:

a. A detailed confirmation of receipt within 10 business days of receiving a shipment (via the Detailed Confirmation of Receipt form);

b. Supplementary activity reports on a periodic basis as requested by AmeriCares that include: narrative on programmatic achievements and challenges; narrative and/or photographic accounts of the impact of product donations on patients, health care workers or recipient institutions; other information or reporting on special projects (i.e. grants, targeted donations and/or special corporate-sponsored projects).

17. Affiliate agrees to provide additional information as requested by AmeriCares. This is especially important when this information will be used to satisfy donor queries.

VI. Indemnity

18. Each of the parties agree to indemnify and hold the other harmless, as well as their respective employees, agents, or officers, from any and all claims, demands, causes of action, lawsuits and any liability brought by any third person arising out of the claimed misfeasance, malfeasance, action or inaction of the indemnifying party, their respective employees, agents, or officers.

19. The indemnities contained in this agreement shall survive the termination of this Agreement, insofar as they pertain to events/occurrences that transpire during the period of the Agreement.

VII. Suspension/Termination of Agreement

20. AmeriCares may suspend Affiliate shipments and agreement activities, in the event that the Affiliate fails to comply with the principles and/or terms set out in this agreement.

21. Either organization may terminate this Agreement upon thirty (30) days written notice. Before termination, Affiliate agrees to submit a detailed listing in writing of any AmeriCares donations remaining in its possession as well as stock remaining at recipient institutions. Affiliate agrees to work with AmeriCares on a plan for usage, distribution, return of stock to AmeriCares, or destruction of remaining inventory prior to agreement termination.

VIII. Dispute Resolution

22. Any claim, dispute and other unresolved matter in question arising out of, or related to, this Agreement shall be subject to arbitration which, unless the parties mutually agree otherwise, shall be 1) administered by the American Arbitration Association in accordance with the rules and procedures of the International Centre for Dispute Resolution, then in effect, and 2) conducted in the City of Stamford, Connecticut, USA.

23. A demand for arbitration shall be made within a reasonable time after the claim, dispute or other matter in question has arisen. In no event shall the demand for arbitration be made after the date when institution of legal or equitable proceedings based on such claim, dispute or other matter in question would be barred by the applicable statute of limitations.

24. The award rendered by the arbitrator or arbitrators shall be final, and judgment may be entered upon it in accordance with applicable law in any court having jurisdiction thereof.

2013-2018 IAP LHD WORK PLAN OUTLINE

GOAL 1: Increase childhood immunization rates 1-2% each year

Choice of AFIX vs Daycar 79 *

Validate NYSIIS county rates

Conduct AFIX or Daycare visits/audits

GOAL 2: Increase adult immunization rates (influenza and pneumococcal) by 10% over 5 years

1st year document baseline measure of community mobilization activities: ie distribute ed. Materials

j

Outreach activities through community partnerships ie AIM

Increase number adults vaccination site reporting to NYSIIS

Increase imm. Rates among underserved

(Tdap) Gift program

1/13 Hosp mandated to offer Tdap to fathers/ grandparents

GOAL 3: Ensure all vaccination records are completely entered into NYSIIS

GOAL 4: Increase Education, information, training and partnerships

Staff to view CDC programs live or taped

IN office or Out of office training other than AFIX VISITS for ? 30% VFC providers

Promote NIVW and at least one other observance to patients, consumer

Groups, employee health services, long term care facilities schools etc.

Ensure completion of annual school survey

GOAL 5: Eliminate perinatal Hepatitis B

SCHEDULE "A"

AUTHORIZATION TO ATTEND MEETING OR CONVENTION

Check one:

☐ In-State (needs Supervisory Committee authorization)

☒ Out-Of State (needs Board resolution)

The Health Services (Supervisory Committee) hereby authorizes Sharon Schaldone Tammie DeLorenzo (Employee Name)

to attend Delta Health Technologies 2013 National Customer Forum (Name of meeting or organization)

at Blair County Convention Center Altoona, PA (Address)

on 6/24/13 - 6/27/13 (Dates) Mode of transportation to be used Health Services Fleet vehicle (County Vehicle or Mass Transportation)

If the mode of transportation is not a county vehicle or mass transportation, please explain:

Health Services Fleet vehicle

Proper documentation must be attached when submitting for approval.

(Please check documents attached)

☒ Notice of meeting or convention including cost.

conf 399 x 2 = 798
lodging 297
plus food and incidental exp. paid at GSA Rates with receipts presented

For Overnight Travel

☒ Room rate $ 99 x 3 nites = GSA* Rate $ 77

☐ Meal costs - GSA*per diem rate $ 46

*www.gsa.gov

Date: 4/24/13 Patricia [signature] Department Head Signature

Date: 4/26/13 [signature] Committee Chairman Signature

Please refer to the Warren County Travel Policy and County Vehicle Use Regulations for general policy guidelines.

****

Please check to request a fleet vehicle.

☐ **REQUEST FOR USE OF FLEET VEHICLE**

****

Filing Instructions:

1. Original with voucher to Auditor.
2. Copy to Frank Morehouse if fleet vehicle is needed.
3. Copy to Clerk of the Board with Resolution Request form if out-of-state travel.
4. Copy to Purchasing with Purchase Order, if required.
5. Copy to Commissioner of Administrative and Fiscal Services if credit card will be used.

RESOLUTION REQUEST FORM NO. 15

Requesting Approval for Out-Of-State Travel*

*If the conference announcement or details are available in writing, please attach.

DEPARTMENT NAME: Health Services

DATE: 04/26/2013

(a) Dates of Travel: 06/24/2013 – 06/27/2013

(b) Purpose (include complete name of any conference, school, etc.):
To attend the Delta Health Technologies 2013 National Customer Forum

(c) City/Town & State:
Altoona, PA

(d) Employee(s) Traveling (include title(s)):
Sharon Schaldone – ADPS
Tammie DeLorenzo – Clinical and Fiscal and Information Coordinator

(e) Is County paying the costs or is another Agency?
County

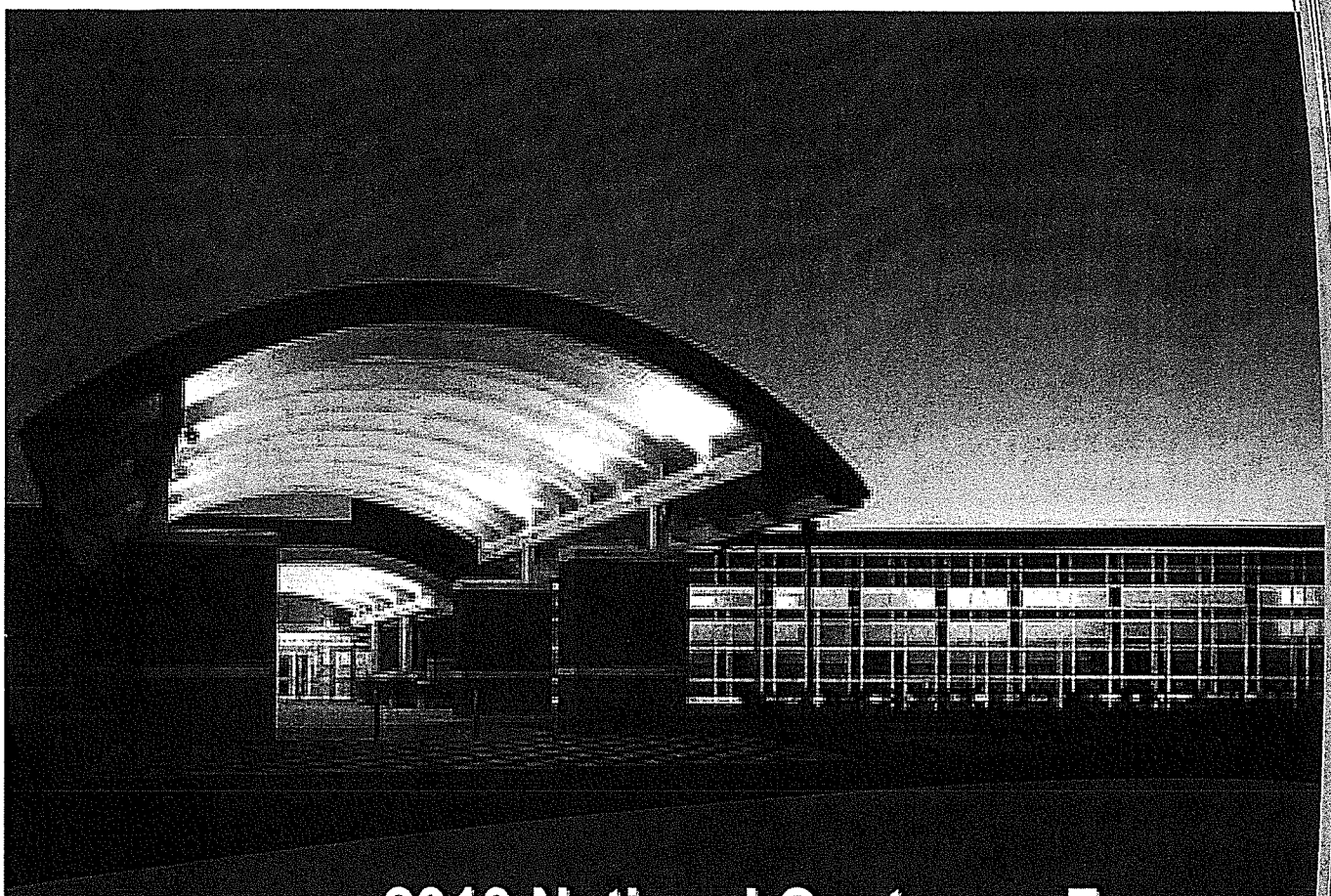
(f) Mode of Transportation to be Used:
County Vehicle from Health Services Fleet

(County Vehicle or Mass Transportation)

Please note: If County vehicle use is requested, upon resolution approval, please provide Fleet Manager Frank Morehouse with vehicle request form properly completed.

Delta Health Technologies

The Power of Focus



2013 National Customer Forum Registration Information

INTRODUCTION

What is the National Customer Forum?

The National Customer Forum is an annual event whose principle objective is to advance the effective use of Delta's software solutions. Agencies have the opportunity to attend sessions conducted by their peers and industry experts. The event focuses on education, product demonstrations, networking and exchanging ideas with peers, and social activities including the Altoona Curve Baseball game and going "Back to the Future".

Who Should Attend?

The National Customer Forum represents users of all of Delta's software applications (AppointMate, Crescendo™ and Encore®). All levels of users are welcomed and encouraged to attend. Sessions are designed for managers, system administrators, caregivers, data entry personnel, medical records personnel, and other Encore application users.

Why Should You Attend?

The National Customer Forum is an opportunity for you to discover how to maximize the Delta's software applications and related software through scheduled sessions and contact with other users. You will learn about the future direction of Delta solutions, and what benefits we can offer you and your agency.

What Will You Take Home?

You will return home with a vision of how information systems in the healthcare industry will help you meet the future challenges of your agency. You will gain new ideas, ways to improve the use of your computer system, detailed knowledge of selected topics, information about new systems, and new friends.

Table of Contents

DeltaHealth Technologies

400 Lakemont Park Boulevard · Altoona, PA 16602

Tel: 800.444.1651 · Fax: 814.942.0125 · www.DeltaHealthTech.com

April 12, 2013

Dear Valued Customer,

Since 1991 we have invited our customers to Central Pennsylvania to take part in an opportunity to network with other users and learn more about the services and solutions we provide. This year we are extending that same invitation. The National Customer Forum will be held at the Blair County Convention Center in Altoona, PA on June 25, 26, and 27, 2013. The forum gives you, our valued customers, the chance to meet with each other and our employees, discuss concerns and solutions, and learn more about Delta Health Technologies® and our plans for the future.

We are once again featuring sessions presented by your peers on the subjects in which they have expertise. We are also excited to have industry experts present on topics such as ICD-10, payment models, revenue cycle management and more.

The registration fee is $449 per person. Our early bird special is $399 per person, for those whose enrollment forms are postmarked or faxed *on or before* May 15, 2013. Registrations received *after* June 7, 2013, are $499 per person. The one-day registration fee is $149 per person. When you have completed your registration, you will receive an acknowledgement via email. If you completed your online registration and haven't received an email acknowledgement within one week, please contact Crystal Parks at (814) 949-7862.

The registration fee includes:

- Choice of sessions
- Scheduled transportation as needed between participating hotels and the convention center
- Continental breakfast on Tuesday, Wednesday, and Thursday
- Catered luncheon on Tuesday, Wednesday, and Thursday
- Admittance to an Altoona Curve Baseball Game and dinner Tuesday evening
- Back to the Future dinner and dance on Wednesday evening

This booklet contains all the pertinent information you'll need prior to registering online. To register, simply access the Delta National Customer Forum 2013 registration page. We encourage you to read all the materials and to make your travel and lodging reservations.

We look forward to seeing you in June!

Sincerely,

Keith R. Crownover
President & CEO

Sessions by Track

The following tracks are being offered.

Crescendo (C)

Encore (E)

Industry (I)

Private Pay / Non-Medical Home Care (P)

Crescendo

Tuesday, June 25, 2013

12:30 p.m. to 2:00 p.m.	Crescendo Home Health
2:15 p.m. to 3:45 p.m.	Quality Flow for Home Health

Wednesday, June 26, 2013

10:15 a.m. to 11:45 a.m.	Crescendo Home Health
1:00 p.m. to 2:30 p.m.	I've Got the Power
2:45 p.m. to 4:15 p.m.	**Crescendo Hospice**

Thursday, June 27, 2013

9:00 a.m. to 10:30 a.m.	Crescendo Home Health
10:45 a.m. to 12:15 p.m.	Staff and Service Management

Encore

Tuesday, June 25, 2013

2:15 p.m. to 3:45 p.m.	Keeping Your Back Office Clean

Wednesday, June 26, 2013

10:15 a.m. to 11:45 a.m.	Troubleshooting Tools for PPS Billing/Remittance
1:00 p.m. to 2:30 p.m.	Learn How to Be the Best Champion User for Your Agency
2:45 p.m. to 4:15 p.m.	QAM – How to Track Patients through Certification / Recertifcation Process

Thursday, June 27, 2013

10:45 a.m. to 12:15 p.m.	Ask the Expert (Consultant Forum)

Sessions by Time

Tuesday, June 25, 2013 • 12:30 p.m. to 2:00 p.m.

Crescendo

Crescendo Home Health

Come see an in-depth product review of Crescendo. Crescendo allows you to easily assess and evaluate a patient's progress so you are not distracted from the primary goal of giving care. Our decision support workflow tools provide a care plan based on patient information. Patient-centered care lies at the heart of Crescendo, displaying patient information – such as disciplines admitted, diagnosis, risk scores and current medications – on a single dashboard screen.

Faculty: Rob Stoltz, Director of Strategic Accounts, Delta Health Technologies

Industry

Why Do You Need a Business Analyst?

Struggling to have the business intelligence you need to run your agency? In this session, the speakers will present the value of using analytics to keep your agency on the cutting edge. The presentation will also include the how to's of getting the right business analyst who can engage senior leadership and clinical team leaders by using data. An in-depth discussion of using benchmarking tools and data to improve clinical care and operational workflows will be included. Discussion will also include creating an environment where analytics becomes part of the fabric of the agency operations.

Faculty: George Haydon, CIO, and Bonnie Thackston, BI Analyst, VNA of Cape Cod, Hyannis, MA

Private Pay / Non-Medical Home Care

AppointMate Staff and Scheduling Service

This session will focus on the benefits of the employee and client calendars. Attendees will learn how AppointMate matches client needs with caregivers' skills, availability and location and suggests the best caregiver for each client based on 10 customizable factors. See how AppointMate accounts for travel time and mileage, acts as a virtual time clock and alerts office staff to overdue appointments.

Faculty: Sara Maynard, AppointMate Training and Support Manager, Delta Health Technologies

Tuesday, June 25, 2013 • 2:15 p.m. to 3:45 p.m.

Crescendo

Quality Flow for Home Health

This session will provide the attendee with the highlights of the functionality for oversight of ICD coding, and OASIS management within Crescendo from the Intake process to the important OASIS review. Also included will be a review of the verbal orders process that is provided within the Crescendo application. Crescendo offers reviewers a tool that will promote accurate documentation and efficient workflow processes at an agency.

Faculty: Julie Peterson, RN, MS, Consulting & Implementation Manager, Delta Health Technologies

Sessions by Time Continued

Wednesday, June 26, 2013 • 10:15 a.m. to 11:45 a.m.

Crescendo

Crescendo Home Health

Come see an in-depth product review of Crescendo. Crescendo allows you to easily assess and evaluate a patient's progress so you are not distracted from the primary goal of giving care. Our decision support workflow tools provide a care plan based on patient information. Patient-centered care lies at the heart of Crescendo, displaying patient information – such as disciplines admitted, diagnosis, risk scores and current medications – on a single dashboard screen.

Faculty: Rob Stoltz, Director of Strategic Accounts, Delta Health Technologies

Encore

Troubleshooting Tools for PPS Billing / Remittance

This session will provide an overview of how PPS claims are generated from start to finish. A process flow will be presented showing how different areas of the Encore affect the generation of PPS claims. Emphasis will be on using tools within Encore to troubleshoot reasons why a claim fails to generate or why PPS remittance does not match PPS claim amounts.

Faculty: Tiffanie Dietzel, Support Analyst, and Amy Hileman, Support Analyst, Delta Health Technologies

Industry

Care Transition: A Value-Based Model for Business Growth

This session will provide a framework for post-acute providers in establishing a successful care transitions program to reduce avoidable hospitalizations. Several key strategies to cultivate partnerships with hospitals and other post-acute care providers will be addressed. Both the challenges and benefits to the implementation of an evidence-based model are also explored.

Faculty: Celeste Twarden, Vice President, Home Nursing Agency & VNA, Altoona, PA

Wednesday, June 26, 2013 • 1:00 p.m. to 2:30 p.m.

Crescendo

I've Got the Power

Learn how to use the dynamic and powerful maintenance features of Crescendo to enhance the base form library to address the ever changing documentation needs of your organization.

Faculty: Bonnie Yingling, Product Owner, and Andy Ostinowsky, Productization Analyst, Delta Health Technologies

Sessions by Time Continued

Wednesday, June 26, 2013 • 2:45 p.m. to 4:15 p.m. Continued

Industry

Impact of Regulations on Revenue Cycle Management

Home health providers face many challenges on a daily basis in simply getting paid for the care they provide. With increasing regulations and compliance rules that govern reimbursement, home health providers need real solutions to alleviate the stress of complying with those requirements. Some of the common and complex revenue cycle issues that agencies face and provide solutions for troubleshooting these problems will be discussed.

Faculty: Nick Seabrook, Managing Director, BlackTree Healthcare Consulting

Thursday, June 27, 2013 • 9:00 a.m. to 10:30 a.m.

Crescendo

Crescendo Home Health

Come see an in-depth product review of Crescendo. Crescendo allows you to easily assess and evaluate a patient's progress so you are not distracted from the primary goal of giving care. Our decision support workflow tools provide a care plan based on patient information. Patient-centered care lies at the heart of Crescendo, displaying patient information – such as disciplines admitted, diagnosis, risk scores and current medications – on a single dashboard screen.

Faculty: Scott Brasher, RN, Implementation Specialist, and Shane Nesler, Sales Engineer, Delta Health Technologies

Industry

Benefits of Cloud Technology

This session will provide a high-level overview of Cloud technologies used in the Delta Health Technologies Datacenter and how it benefits the customer. Discussion topics include: overview of cloud technology, infrastructure (scalability), performance / maintenance, security, and support.

Faculty: Doug Lockard, Senior Network Administrator, and Mike Snyder, Network Administrator, Delta Health Technologies

The Time is Now! Prepare Your Agency for ICD-10

Now is the time to prepare for ICD-10. The transition to the new code set will affect every facet of your agency. The home health industry has an opportunity to prepare and implement a training plan for all employees in 2013. Knowing when to provide the right education at the right time is imperative to an agency's success in a looming ICD-10 environment. Topics include the differences between ICD-9-CM and ICD-I0-CM, the impact on the home health industry, the readiness of the home health industry today, the importance of agency preparation and training. Learning objectives include: discuss history of ICD-9-CM, explain purpose of ICD-IO-CM, analyze ICD-I0-CM code structure, contrast differences between ICD-9-CM and ICD-I0-CM, discuss home health industry readiness, discuss importance of preparation, and identify impact on home health industry.

Faculty: Tricia A. Twombly, BSN, RN, HCS-D, HCS-O, COS-C, CHCE, AHIMA Approved ICD-10 CM Certified Trainer, Decision Health

Evening Events

Let Us Take You Out To A Ballgame!

Join us Tuesday, June 25, at the Blair County Ballpark as the Altoona Curve – Double A affiliate of the Pittsburgh Pirates – host the New Britain Rock Cats

A pre-game picnic will begin at 6:00 p.m.
Game time is 7:00 p.m.

A lucky customer will have the opportunity to throw out the first pitch!
Transportation will be provided between the lodging properties on page 16 and the Blair County Ballpark.

SAVE THE DATE

Go Back to the Future!

Delta Health Technologies would like to take you **Back to the Future**!
The evening will begin with dinner and a stroll down memory lane, followed by the Enchantment under the Sea dance (including a Music Video Dance Party) at 6:00 p.m. on Wednesday, June 26.

Pick a character from the Back to the Future movie and dress accordingly. Look for a replica of Marty's orange quilted vest or just throw on a white lab coat and a headlamp and go as Doc Brown. Suggestions for the 80's, find some parachute pants, off-the-shoulder sweatshirts, and neon tees. Acid-wash jeans and leg warmers work as well. For the 50's, go for bobby-socks and saddle shoes, poodle skirts. The men can wear rolled up jeans and bowling shirts.

Registration Information

Fees

Registration fees per person:

$399.00	For registrations received *on or before* **May 15, 2013**
$449.00	For registrations received *after* **May 15, 2013** and *before* **June 7, 2013**
$499.00	For registrations received *after* **June 7, 2013**
$299.00	**Serving More Clients** workshop on Wednesday, June 26, 2013
$149.00	For **One Day Only** registrations (excluding the **Serving More Clients** workshop)
Free	Customer Presenters

Registration

Each attendee is required to register online.

Once you have completed your online registration, we encourage you to send your payment by check.

You may mail your payment to:

Delta Health Technologies
c/o National Customer Forum
400 Lakemont Park Blvd.
Altoona, PA 16602

All registration inquiries should be directed to the National Customer Forum Committee via email at NCFCommittee@DeltaHealthTech.com.

Cancellations

To receive a refund, send your cancellation request to the National Customer Forum Committee at Delta. Refunds will not be given until after the event. No refunds will be given for cancellations received on or after June 7, 2013. Registrations are transferrable to another representative from your agency.

Travel Information

Please note that the area surrounding the Blair County Convention Center, as well as the preferred lodging properties, is adjacent to shopping centers and eating establishments; however, due to safety concerns, pedestrian travel is not recommended.

Car Rental

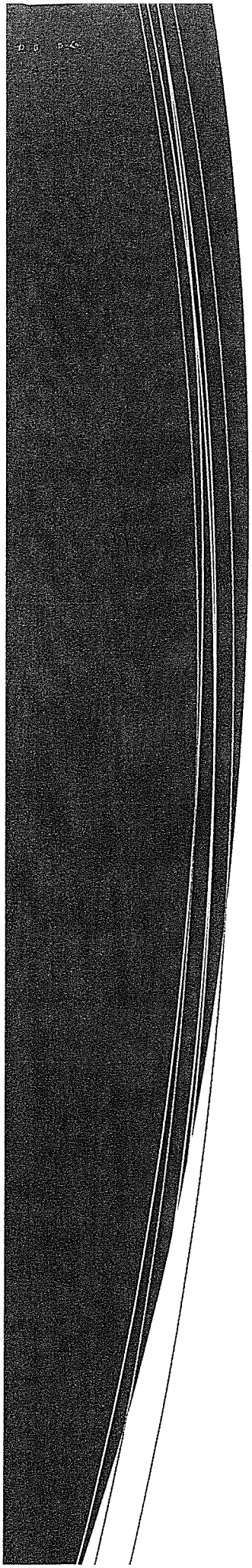
Car rental agencies are available on-site at the Altoona/Blair County and State College Airports. Please contact your travel agent for additional information.

Limousine Service

Guests must make arrangements directly with the service providers in advance of arrival date. Suggested companies: Black Diamond & Classic Limousine (814) 942-9100 and St. Topaz Limousine (814) 944-2934.

Taxi Service

Taxi service provided by Yellow Cab (814) 944-6105. It is recommended that you make arrangements with the service provider in advance of the arrival date.



Delta Health Technologies
The Power of Focus
400 Lakemont Park Blvd.
Altoona, PA 16602
P: 814.944.1651
F; 814.942.4618
www.DeltaHealthTech.com

SCHEDULE "A"

AUTHORIZATION TO ATTEND MEETING OR CONVENTION

Check one:

☒ In-State (needs Supervisory Committee authorization)

☐ Out-Of State (needs Board resolution)

The Health Services (Supervisory Committee) hereby authorizes Cathy Dufour PHN (Employee Name)

to attend Home Care Assoc. of NYS ICD-9-CM and Oasis Coding Workshop and the Recertification Test (Name of meeting or organization)

at Hilton Garden Inn is Crossroads Ct. Newburgh NY (Address)

on Sept. 16-18 2013 (Dates) Mode of transportation to be used Health Services Fleet Vehicle (County Vehicle or Mass Transportation)

If the mode of transportation is **not** a county vehicle or mass transportation, please explain:

Proper documentation must be attached when submitting for approval.

(Please check documents attached)

☒ Notice of meeting or convention including cost. $399 workshop $189 for Recertification exam

For Overnight Travel

☒ Room rate $ $139 x 2 nites GSA* Rate $ 108

☐ Meal costs - GSA*per diem rate $ 51 . per day

*www.gsa.gov

Date: 4/26/13 Patricia Owen
Department Head Signature

Date: 4/26/13
Committee Chairman Signature

Please refer to the Warren County Travel Policy and County Vehicle Use Regulations for general policy guidelines.

****

Please check to request a fleet vehicle.

☐ **REQUEST FOR USE OF FLEET VEHICLE**

****

Filing Instructions:

1. Original with voucher to Auditor.
2. Copy to Frank Morehouse if fleet vehicle is needed.
3. Copy to Clerk of the Board with Resolution Request form if out-of-state travel.
4. Copy to Purchasing with Purchase Order, if required.
5. Copy to Commissioner of Administrative and Fiscal Services if credit card will be used.

HCA
EDUCATION AND RESEARCH

ICD-9-CM & OASIS Coding
Back to Basics and Beyond

September 17

9:00am to 5:00pm

Hilton Garden Inn
Newburgh/Stewart Airport
15 Crossroads Court
Newburgh, NY 12550
http://hiltongardeninn3.hilton.com
Rooms are $139
Call (845) 567-9500 and ask for the HCA group rate.

Workshop Fee
$349
for HCA Members
• $399 for non-members

Fee includes lunch, handout materials and presentation.

Deadline to Register is September 9.
After that date please include a $15 late fee.
Walk-ins will not be accommodated.

The Home Health Prospective Payment System has made ICD-9-CM coding a key element to determine accurate reimbursement and drive quality outcome improvement. With the advent of Health Care Reform, experts agree that specialized home health training to accurately assign diagnosis codes remains critical to reflect the complexity of home health patients, ensure accurate reimbursement and protect providers from potential adverse results of expanded home health audits. This code conference will provide the fundamentals necessary to achieve national credential status. Ensure your agency coders are recognized for their expertise and experience. Upon completion of this fast-paced, interactive code program, participants will be eligible to take the 2013 Home Care Coding Specialist Diagnosis (HCS-D) National Certification Exam.

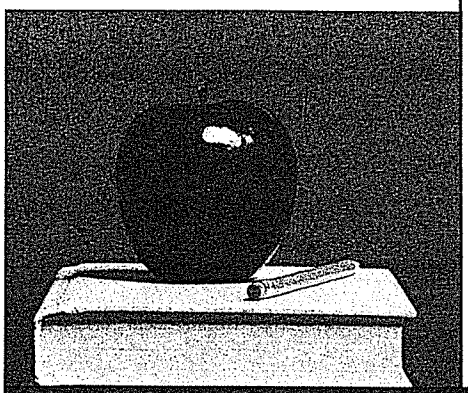
Upon completion of this program participants will be able to:

- Identify and apply updated ICD-9-CM Code Guidelines and Conventions, including the ten steps of correct coding;
- Analyze and apply critical diagnosis related billing and OASIS updates, including the correct assignment of primary, secondary and case mix diagnosis items;
- Assign accurate codes to common and complex home health scenarios, including complex wounds, neoplasms and expanded comorbidities;
- Identify and utilize tips to successfully complete the HCS-D exam.

Participants must have an updated ICD-9-CM Code Manual for this program.

Who Should Attend This Training?
Clinicians as well as non-clinicians involved in the completion of the OASIS assessment.

Presenter:
Patricia W. Tulloch, RN, B.S.N, M.S.N., HCS-D, Senior Consultant, RBC Limited



HCS-D Exam
September 18
The **2013 Home Care Coding Specialist Exam** (HCS-D) will be offered on September 18, at this same location from 9am – 11:30am. **Separate registration is required.** The exam is based on the 2013 ICD-9-CM Manual. It is *RECOMMENDED* that the participant planning to take the code certification test has at least two years of current home health coding experience to successfully achieve certification.

Those registered for the exam may participate in a two hour study session on the evening of September 17 with Ms. Tulloch. This review session is a must for test-takers!

www.hca-nys.org

Board of
Medical Specialty
Coding & Compliance

Home Care Association of New York State (HCANYS)
EXAM REGISTRATION FORM
HOME CARE CODING SPECIALIST (HCS-D)

☐ Register me for the **2013** Home Care Coding Specialist - Diagnosis (HCS-D) certification examination on September 18, 2013, in Newburgh, NY.

_____ I am an HCANYS member. My registration fee is $269.10

_____ I am not an HCANYS member. The standard registration fee is $299.00

☒ Register me for the **2013** Home Care Coding Specialist - Diagnosis (HCS-D) Recertification examination on September 18, 2013 in Newburgh, NY. (**Open to HCS-D credential holders due for recertification**). The standard registration fee is $189.00.

☐ I want to take the HCS-D exam **ONLINE** at my office location after the conference. I understand that I must submit a Proctor Nomination Form and agree to follow the BMSC Individual Proctoring Protocol (IPP). *Forms may be downloaded at:* www.medicalspecialtycoding.com.

**Your certification and recertification examination fees include a one-year membership in the Association of Home Care Coding & Compliance. Visit http://ahcc.decisionhealth.com for more information on membership.*

CANDIDATE INFORMATION

Name: Cathy M. DuFour Title: PHN / Coder

Organization: Warren County Health Services

Address: 1340 State Route 9 City: Lake George State: NY Zip: 12845

Phone: (518) 761-6415 Fax: (518) 761-6562 Email: dufourc@warrencountyny.gov

PAYMENT INFORMATION

☐ Credit Card ☐ VISA ☐ MC ☐ AMEX ☐ Discover

Card #: _____ Expiration _____

Cardholder: _____ Signature _____

☐ Check enclosed Payable to Registrar, BMSC (TIN 52-2205881)

Fax (301) 287-2535 ▪ **Call** (800) 897-4509

▪ **Mail** Attn Registrar: BMSC, 9737 Washingtonian Blvd., Ste 200, Gaithersburg, MD 20878-7364

Please Note: The HCS-D examination contains 50 questions, and you will be allowed 2 ½ hours to complete the examination. You will receive your examination results via USPS within 4 weeks of taking your examination. We recommend that those attendees who plan to take the HCS-D credential examination prepare for the test with self study in addition to this onsite training program. Please visit our website to learn more about the HCS-D certification.