

WARREN-HAMILTON COUNTIES OFFICE FOR THE AGING  
1340 STATE ROUTE ♦ LAKE GEORGE, NY 12845  
PH#(518)761-6347 ♦ FAX#(518)761-6344

**HUMAN SERVICES COMMITTEE MEETING  
OFFICE FOR THE AGING AGENDA  
April 24, 2018 9:00AM**

Committee Members: Chairman Edna Frasier, Peter McDevitt, Claudia Braymer, Craig Leggett, William Loeb, Jack Diamond, Cynthia Hyde, Brad Magowan, Matthew Sokol

- I. Committee meeting called to order by Chairman
- II. Motion to approve minutes of prior Committee meeting
- III. Action Agenda
  1. **Request:** Permission to amend Resolution 76 of 2018.  
**Rationale:** The amount of the transportation contract with the Town of Lake George should be \$3,665. It was listed incorrectly as \$3,715 in the contract.
  2. **Request:** Amend contracts with MLTCs (Managed Long Term Care) to allow the incorporation of the Standard Clause Amendment and to authorize the chairman to execute any further amendments which do not increase the cost to the county or change the term of the contract without need for further Board of Supervisor approval in a form approved by the County Attorney.  
**Rationale:** Many of the new contracts have this language already, but some of the previous contracts with MLTCs did not have the updated version of the Standard Clause amended by the New York State Department of Health on 4/1/2017.
- IV. Referral/pending items- N/A
- V. Information for Discussion/Review
  - a) Senior Luncheon – Friday, June 1<sup>st</sup>, at the Holiday Inn in Lake George. Invitations have been sent to the Supervisors.
- VI. Privilege of the Floor to discuss any additional items to come before the Committee
- VII. Motion to adjourn

**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:** Warren/Hamilton Counties Office for the Aging

**DATE:** 3/21/18

- (a) Purpose of Request: Amend CSE Contracts - Resolution 76 of 2018
- (b) Details: Amount of transportation contract with the Town of Lake George was listed incorrectly and should have been \$3,665.00
- (c) Previous Resolution Number: 76 of 2018
- (d) Where are the Funds (if required)? List Budget Code, Object Code, Full Title\* and Amount:

Sample: A.8021 470 Planning & Community Development – Contract

\* as listed in budget and LOGOS

# Warren County Board of Supervisors

## RESOLUTION NO. 76 OF 2018

RESOLUTION INTRODUCED BY SUPERVISORS FRASIER, MCDEVITT, BRAYMER, LEGGETT, LOEB, DIAMOND, HYDE, MAGOWAN AND SOKOL

**AMENDING RESOLUTION NO. 118 OF 2016, WHICH AUTHORIZED AGREEMENTS WITH VARIOUS ORGANIZATIONS UNDER THE COMMUNITY SERVICES FOR THE ELDERLY PROGRAM WITH OFFICE FOR THE AGING, TO ADJUST CONTRACT AMOUNTS**

WHEREAS, pursuant to Resolution No. 118 of 2016, Warren County authorized agreements (previously authorized by Resolution No. 130 of 2015) with various organizations to provide services under the Community Services for the Elderly Program (CSE), and

WHEREAS, the Director of Office for the Aging has requested to adjust the amount of the agreements under the Community Services for the Elderly Program (CSE), now, therefore, be it

RESOLVED, that the Chairman of the Board be, and hereby is, authorized to execute amendment agreements with the various organizations outlined on the attached Schedule "A" to adjust the amount of the agreements, and be it further

RESOLVED, that unless there should be a material change in contract terms or provisions or a change in the amount of the contracts, these agreements may be continually renewed and the Chairman of the Board of Supervisors is authorized to execute such agreements without the need for a further Board Resolution, upon mutual agreement of the parties and provided appropriations for same are included in the Office for the Aging budget, and be it further

RESOLVED, that these agreements shall automatically terminate upon the discontinuance of State or Federal funding available for such contract purpose, and be it further

RESOLVED, that other than the changes outlined herein, all other terms and conditions of Resolution No. 118 of 2016 will remain the same.

SCHEDULE "A"						
Community Services For The Elderly						
Subcontractor	Service Provided	State funds	County funds	Pd to Contractor	Contributions	TOTALS
Glens Falls Assoc. for the Blind, Inc.	Services for the Blind-	\$6,120.00	\$1,530.00	\$7,650.00		\$7,650.00
Greater Adirondack Home Aides, Inc.	In-Home Services/Case Mgmt	\$14,280.00	\$3,570.00	\$17,850.00		\$17,850.00
Greater GF Senior Citizens Ctr., Inc.	Outreach	\$21,200.00	\$5,300.00	\$26,500.00		\$26,500.00
Legal Aid Society	Legal Assistance	\$14,360.00	\$3,590.00	\$17,950.00		\$17,950.00
Town of Chester	Transportation	\$3,016.00	\$755.00	\$3,771.00		\$3,771.00
Town of Hague	Transportation	\$768.00	\$192.00	\$960.00		\$960.00
Town of Horicon	Transportation	\$2,008.00	\$502.00	\$2,510.00		\$2,510.00
Town of Johnsonburg	Transportation	\$3,238.00	\$810.00	\$4,048.00		\$4,048.00
Town of Lake George	Transportation	\$2,972.00	\$743.00	\$3,715.00		\$3,715.00
Town of Lake Luzerne	Transportation	\$2,313.00	\$579.00	\$2,892.00		\$2,892.00
Town of Lake Pleasant	Transportation	\$915.00	\$229.00	\$1,144.00		\$1,144.00
Town of Long Lake	Transportation	\$3,640.00	\$910.00	\$4,550.00		\$4,550.00
Town of Stony Creek	Transportation	\$1,344.00	\$336.00	\$1,680.00		\$1,680.00
Town of Thurman	Transportation	\$1,437.00	\$360.00	\$1,797.00		\$1,797.00
Town of Warrensburg	Transportation	\$1,304.00	\$326.00	\$1,630.00		\$1,630.00
Town of Wells	Transportation	\$640.00	\$160.00	\$800.00		\$800.00
Warren/Hamilton Counties A.C.E.O., Inc.	Handyman Program	\$5,384.00	\$1,346.00	\$6,730.00		\$6,730.00
Hamilton County Public Health	Health Promotion	\$2,650.00	\$663.00	\$3,313.00		\$3,313.00
Warren County Public Health	Health Promotion	\$4,400.00	\$1,100.00	\$5,500.00		\$5,500.00
<b>TOTAL</b>		<b>\$91,989.00</b>	<b>\$23,001.00</b>	<b>\$114,990.00</b>		<b>\$114,990.00</b>

## ***RESOLUTION REQUEST FORM NO. 4***

### ***Request for Extending, Rescinding or Amending Existing Contract***

**DEPARTMENT NAME: OFA**

**DATE: April 12, 2018**

- (a) Purpose of Contract Change: **Amend contracts with MLTCs (Managed Long Term Care) to allow the incorporation of the Standard Clause Amendment and to authorize the chairman to execute any further amendments which do not increase the cost to the county or change the term of the contract without need for further Board of Supervisor approval in a form approved by the County Attorney.**
- (b) Resolution Number, or Numbers if Amended, which Authorized the Original Contract: **41 of 2015**
- (c) Name of Contractor:
- (d) Address of Contractor:
- (e) Contractor's Contact Person and Telephone Number:
- (f) Commencement Date of Extension: **2/1/2018**
- (g) Termination Date of Extension: **Per terms of the agreement**
- (h) Payment Provisions:
  - 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, Object Code, Full Title\* and Amount: **OR Capital Project OR Capital Reserve Project Number, and Title, and Amount: **Not Applicable****

Sample: A.1010 470 Legislative Board – Contract Sxx.xx  
Capital Project No. H289.9550 480 – Old Jail Renovations Sxx.xx

\*as listed in budget and LOGOS

**AMENDMENT TO THE AGREEMENT  
BETWEEN  
VNA Homecare Options, LLC  
AND  
Warren-Hamilton Counties Office for the Aging  
1340 State Route 9, Lake George, NY 12845**

The above-named Agreement, dated the 1<sup>st</sup> Day of January 2015, is hereby amended effective February 1, 2018 by adjusting the Standard Clauses for New York State to reflect the most recent changes.

Rates and Billing Procedures:

**NYS Standard Clauses**

The Standard Clauses for New York State have been updated and are in effect as of 04/01/2017. Appendix A is attached with updated clauses.

Contractor may amend this agreement from time-to-time as necessary to include additional Medicaid and/or Medicare Programs applicable to Contractor's beneficiaries ("Program (s)"). Subcontractor agrees that Subcontractor will participate in all new Programs for which Subcontractor is qualified as determined by Contractor pursuant to applicable federal and New York guidelines. Participation may include changes to reimbursement methods, including Value Based Payment incentives as directed by The Center for Medicare and Medicaid (CMS) and The New York State Department of Health (NYSDOH). Subcontractor's participation in any new Program will be effective upon thirty (30) calendar days written notice of Contractor amendment of this agreement.

All other terms and conditions of the above named Agreement remain intact.

Agreed to by and between:

VNA Homecare Options LLC

Warren-Hamilton Counties Office for the Aging

\_\_\_\_\_  
M. Kate Rolf

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name, Title

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

(Initial) VNAHCO \_\_\_\_\_

(Initial) Subcontractor \_\_\_\_\_

# New York State Department of Health

## Standard Clauses for Managed Care Provider/IPA/ACO Contracts

APPENDIX A  
Revised 04/01/2017

(Initial) VNAHCO \_\_\_\_\_

(Initial) Subcontractor \_\_\_\_\_

Notwithstanding any other provision of this agreement, contract, or amendment (hereinafter "the Agreement " or "this Agreement ") the Article 44 plans and providers that contract with such plans, and who are a party 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/ACO, or between an IPA/ACO and an IPA/ACO, such clauses must be included in IPA/ACO 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 a comprehensive health services plan, or a health and long term care services plan.

"Independent Practice Association" or "IPA" shall mean an entity formed for the limited purpose of contracting for the delivery or provision of health services by individuals, entities and facilities licensed and/or certified to practice medicine and other health professions, and, as appropriate, ancillary medical services and equipment. Under these arrangements, such health care Providers and suppliers will provide their service 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 (DOH) and if implemented prior to such approval, the parties agree to incorporate into this Agreement any and all modifications required by DOH for approval or, alternatively, to terminate this Agreement if so directed by DOH, 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 DOH, and any such amendment shall be submitted for approval in accordance with the appropriate procedures and timelines described in Sections III and VII of the New York State Department of Health Provider Contract Guidelines for MCOs and IPA/ACOs. 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, as may be required by the Medicaid Managed Care contract between the MCO and DOH.

3. Assignment of an agreement between an MCO and (1) an IPA/ACO, (2) an institutional network Provider, or (3) a medical group Provider that serves five percent or more of the enrolled population in a

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county, or the assignment of an agreement between an IPA/ACO and (1) an institutional Provider or (2) a 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/ACO or between an IPA/ACO and an IPA/ACO, the IPA/ACO agrees and shall require the IPA/ACO'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, contract, or DOH or DFS guidelines or policies and (b) has provided to the Provider at least thirty 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/ACO, or between an IPA/ACO and an IPA/ACO, the IPA/ACO 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 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/ACO that 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/ACO'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, Chapter 237 of the Laws of 2009, Chapter 297 of the Laws of 2012, Chapter 199 of the Laws of 2014, Part H, Chapter 60, of the Laws of 2014 and Chapter 6 of the Laws of 2015 with all amendments thereto.

9. To the extent the MCO enrolls individuals covered by the Medical Assistance Program, this Agreement incorporates the pertinent MCO obligations under the Medicaid Managed Care contract between the MCO and DOH as set forth fully herein, including:

- a. The MCO will monitor the performance of the Provider or IPA/ACO under the Agreement and will terminate the Agreement and/or impose other sanctions if the Provider's or IPA/ACO's performance does not satisfy the standards set forth in the Medicaid Managed Care contract.

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b. The Provider or IPA/ACO 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 and that it will take corrective action if the MCO identifies deficiencies or areas of needed improvement in the Provider's or IPA/ACO's performance.

c. The Provider or IPA/ACO agrees to be bound by the confidentiality requirements set forth in the Medicaid Managed Care contract between the MCO and DOH.

d. The MCO and the Provider or IPA/ACO agree that a woman's enrollment in the MCO's Medicaid Managed Care product is sufficient to provide services to her newborn, unless the newborn is excluded from the 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/ACO that are inconsistent with the Medicaid Managed Care contract 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/ACO 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/ACO 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/ACO 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 any 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/ACO agrees to complete and submit the "Certification Regarding Lobbying," Appendix C attached hereto and incorporated herein, if this Agreement exceeds \$100,000. If any funds other than federally appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of a member of Congress, in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant loan, or cooperative agreement, and the Agreement exceeds \$100,000 the Provider or IPA/ACO shall complete and submit Standard Form-LLL "Disclosure Form to Report Lobbying," in accordance with its instructions.

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

i. The Provider or IPA/ACO agrees to monitor its employees and staff against the List of Excluded Individuals and Entities (LEIE), the Social Security Administration Death Master List, and the National Plan Provider Enumeration System (NPPES).

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j. The Provider or IPA/ACO agrees to disclose to the MCO complete ownership, control, and relationship information.

k. The Provider or IPA/ACO agrees to obtain for the 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 DOH, Office of the Medicaid Inspector General (OMIG) or the United States Department of Health and Human Services (DHHS). The information requested shall be provided to the MCO within 35 days of such request.

l. The Provider or IPA/ACO agrees to have an officer, director or partner of the Provider execute and deliver to DOH a certification, using a form provided by DOH through OMIG's website, within five (5) days of executing this agreement, stating that:

The Provider or IPA/ACO is subject to the statutes, rules, regulations, and applicable Medicaid Updates of the Medicaid program and of DOH related to the furnishing of care, services or supplies provided directly by, or under the supervision of, or ordered, referred or prescribed by the Provider. This includes 18 NYCRR 515.2 except to the extent that any reference in the regulation establishing rates, fees, and claiming instructions will refer to the rates, fees and claiming instructions set by the MCO.

All claims submitted for payment by the Provider/IPA/ACO are for care, services or medical supplies that have been provided.

Payment requests are submitted in accordance with applicable law.

m. The Provider or IPA/ACO agrees to require that an officer, director or partner of all subcontractors if they are not natural persons, or the subcontractor itself if it is a natural person, execute a certification, using a form provided by DOH through OMIG's website, before the subcontractor requests payment under the subcontract, acknowledging that:

The subcontractor is subject to the statutes, rules, regulations, and applicable Medicaid Updates of the Medicaid program and of DOH related to the furnishing of care, services or supplies provided directly by, or under the supervision of, or ordered, referred or prescribed by the subcontractor. This includes 18 NYCRR 515.2 except to the extent that any reference in the regulation establishing rates, fees, and claiming instructions will refer to the rates, fees and claiming instructions set by the MCO.

All claims submitted for payment by the subcontractor are for care, services or medical supplies that have been provided.

Payment requests are submitted in accordance with applicable law.

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/ACO or between an IPA/ACO and an IPA/ACO, the IPA/ACO agrees and shall require the IPA's Providers to agree, to comply

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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.

12. Compliance Program. The Provider agrees that if it claims, orders, or is paid \$500,000 or more per year from the Medical Assistance Program, including, in the aggregate, claims submitted to or paid directly by the Medical Assistance Program and/or claims submitted to or paid by any MCO under the Medicaid Managed Care Program, that it shall adopt and implement a compliance program which meets the requirements of New York State Social Services Law § 363-d(2) and 18 NYCRR § 521.3.

13. Compliance Program Certification. The Provider agrees that if it is subject to the requirements of Section B (12) of this Appendix, it shall certify to DOH, using a form provided by OMIG on its website, within 30 days of entering into a Provider Agreement with the MCO, if they have not so certified within the past year that a compliance program meeting the requirements of 18 NYCRR §521.3 and Social Services Law § 363-d(2) is in place. The Provider shall recertify during the month of December each year thereafter using a form provided by OMIG on OMIG's website.

**C. Payment and Risk Arrangements**

1. Enrollee Non-liability. Provider agrees that in no event, including, but not limited to, nonpayment by the MCO or IPA/ACO, insolvency of the MCO or IPA/ACO, 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/ACO) acting on his/her/their behalf, for services provided pursuant to the subscriber contract or Medicaid Managed Care 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, Provider will not bill DOH 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 DOH. 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, the Provider shall maintain and make available to

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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/ACO 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/ACO, 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, where required by Public Health Law §4903, a claim for certain continued, extended, or additional health care services 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 within the required timeframes and under the circumstances described in Public Health Law §4903.

6. The parties agree to follow Section 3224-a of the Insurance Law providing timeframes for the submission and payment of Provider claims to the MCO.

7. The parties agree to follow Section 3224-b(a) of the Insurance Law requiring an MCO to accept and initiate the processing of all claims submitted by physicians that conform to the American Medical Association's Current Procedural Technology (CPT) codes, reporting guidelines and conventions, or to the Centers for Medicare and Medicaid Services' Healthcare Common Procedure Coding System (HCPCS).

8. The parties agree to follow Section 3224-b(b) of the Insurance Law prohibiting an MCO from initiating overpayment recovery efforts more than 24 months after the original payment was received by a health care Provider, except where: (1) the plan makes overpayment recovery efforts that are based on a reasonable belief of fraud or other intentional misconduct or abusive billing; (2) for the Medicaid Managed Care and Family Health Plus programs, the overpayment recovery period for such programs is six years from date payment was received by the health

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care Provider with written notice 30 days prior to engaging in overpayment recovery efforts. Such notice must state the patient's name, service date, payment amount, proposed adjustment, and a reasonably specific explanation of the proposed adjustment.

9. The parties agree to follow Section 3224-c of the Insurance Law providing that claims cannot be denied solely on the basis that the MCO has not received from the member information concerning other insurance coverage.

10. The parties agree that this contract does not waive, limit, disclaim, or in any way diminish the rights that any Provider may have pursuant to Section 3238 of the Insurance Law to the receipt of claims payment for services where preauthorization was required and received from the appropriate person or entity prior to the rendering of the service.

11. The parties agree that for a contract involving Tier 2 or 3 arrangements as described in Section VII.B of the Guidelines, the contract must:

- a. Provide for the MCO's ongoing monitoring of Provider financial capacity and/or periodic Provider financial reporting to the MCO to support the transfer of risk to the Provider; and
- b. Include a provision to address circumstance where the Provider's financial condition indicates an inability to continue accepting such risk; and
- c. Address MCO monitoring of the financial security deposit, describing the method and frequency of monitoring and recourse for correcting underfunding of the deposit to be maintained by the MCO; and
- d. Include a provision that the Provider will submit any additional documents or information related to its financial condition to the MCO, if requested by DOH.

12. The parties agree that for any contract involving an MCO and IPA/ACO, the contract must include provisions whereby:

- a. The parties expressly agree to amend or terminate the contract at the direction of DOH;
- b. The IPA/ACO will submit both quarterly and annual financial statements to the MCO, as well as any additional documents required by the MCO as necessary to assess and ensure the IPA/ACO's progress towards achieving value based payment goals as specified in the Roadmap, and the MCO will notify DOH of any substantial change in the financial condition of the IPA/ACO; and
- c. The IPA/ACO will submit any additional documents or information related to its financial condition to the MCO, if requested by DOH; and
- d. The parties agree that all Provider contracts will contain provision prohibiting Providers, in the event of a default by the IPA/ACO, from demanding payment from the MCO for any covered services rendered to the MCO's enrollees for which payment was made by the MCO to the IPA/ACO pursuant to the risk agreement.

**D. Records and Access**

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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/ACO if applicable) for purposes including preauthorization, concurrent review, quality assurance, (including Quality Assurance Reporting Requirements (QARR)), payment processing, and qualification for government programs, including but not limited to newborn eligibility for Supplemental Security Income (SSI) and for MCO/Manager analysis and recovery of overpayments due to fraud and abuse. The Provider will also make enrollee's 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/ACO if applicable) expressly acknowledges that the Provider 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 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 years after the date of service, and in the case of a minor, for three years after majority or six 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 of service is rendered or at the earliest opportunity, for disclosure of medical records to the MCO, to an IPA/ACO or to third parties. If the Agreement is between an MCO and an IPA/ACO, or between an IPA/ACO and an IPA/ACO, the IPA/ACO agrees to require the Providers with which it contracts to agree as provided above. If the Agreement is between an IPA/ACO 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/ACO, 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/ACO 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'

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notice provided the MCO demonstrates to the satisfaction of DOH, 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/ACO, and the Agreement does not provide for automatic assignment of the IPA/ACO's Provider contracts to the MCO upon termination of the MCO/IPA/ACO contract, in the event either party gives notice of termination of the Agreement, the parties agree, and the IPA/ACO's Providers agree, that the IPA/ACO 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 occurs first. 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/ACO 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 or Medicaid Managed Care 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/ACO and the IPA/ACO's contracted Providers if this Agreement is between the MCO and an IPA/ACO.** 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, the MCO or IPA/ACO 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/ACO agrees to require all participating Providers of its network to assist in the orderly transfer of enrollees to another Provider.

**F. Arbitration**

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/ACO-Specific Provisions**

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Any reference to IPA/ACO Quality Assurance (QA) activities within this Agreement is limited to the IPA/ACO's analysis of utilization patterns and quality of care on

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2018  
*Senior of the Year*

*Please join us for the*

45th Annual Senior Luncheon

*Honoring Seniors from Warren and Hamilton Counties*

Friday, June 1st, from 12-2PM

HOLIDAY INN

(2223 State Route 9, Lake George, NY)

Sign up at your meal site, Senior Club or Office for the Aging  
\$16 per person

Menu

*Garden Salad & Homemade Rolls*

*Sliced London Broil with Gravy, Oven Roasted Potatoes & Seasonal Vegetables or*

*Chicken Parmesan with Pasta & Seasonal Vegetables*

*Coffee, Hot Tea & Soda*

*Cheesecake*

*(optional bar at your own cost)*

Seating is limited, reservations and payment due by Wednesday, May 16<sup>th</sup>.  
Call Jami at the Office for the Aging PH#(518) 761-6347 to reserve your place.