

PACE Managed Long Term Care Model Contract
MISCELLANEOUS/CONSULTANT SERVICES
Updated January 1, 2016
Model for 2012

STATE AGENCY (Name and Address):
New York State Department of Health
Office of Health Insurance Programs
Division of Long Term Care
One Commerce Plaza
99 Washington Avenue
Albany, NY 12210

NYS Comptroller's Number:

Originating Agency Code: 3450000

CONTRACTOR (Name and Address):

TYPE OF PROGRAM:

PACE Managed Long Term Care ~~Plan~~

CHARITIES REGISTRATION NUMBER:

CONTRACT TERM:

CONTRACTOR HAS HAS NOT TIMELY
FILED WITH THE ATTORNEY GENERAL'S
CHARITIES BUREAU ALL REQUIRED
PERIODIC OR ANNUAL WRITTEN REPORTS

FROM: January 1, 201~~6~~⁷
TO: December 31, 20~~1~~⁴⁶

FEDERAL TAX IDENTIFICATION NUMBER:

FUNDING AMOUNT FOR CONTRACT TERM:
~~Based on approved capitation rates~~

MUNICIPALITY NUMBER (if applicable):

STATUS:

CONTRACTOR IS IS NOT
A SECTARIAN ENTITY

CONTRACTOR IS IS NOT
A NOT-FOR-PROFIT ORGANIZATION

CONTRACTOR IS IS NOT
A NY STATE BUSINESS ENTERPRISE

~~(X) IF MARKED HERE, THIS CONTRACT IS NOT
RENEWABLE FOR TWO ADDITIONAL ONE YEAR
PERIODS SUBJECT TO THE APPROVAL OF THE
NEW YORK STATE DEPARTMENT OF HEALTH
AND THE OFFICE OF THE STATE COMPTROLLER~~

BID OPENING DATE: N/A – Contractor is legislatively named in accordance with §4403-f.

APPENDICES ATTACHED AND PART OF THIS CONTRACT

- X APPENDIX A-1 PACE Program Agreement
- X APPENDIX A Standard Clauses for New York State Contracts
- X APPENDIX B New York State Department of Health Guidelines for Contractor Compliance with the Federal Americans with Disabilities Act
- X APPENDIX C Certification Regarding Lobbying
- X APPENDIX D ~~Standard Form LLL Disclosure of Lobbying Activities~~Reserved
- X APPENDIX E-1 Proof of Workers' Compensation Coverage
- X APPENDIX E-2 Proof of Disability Insurance Coverage
- X APPENDIX F Definitions
- X APPENDIX G Conflict Free Evaluation and Enrollment Center (CFEEC)
- X ~~APPENDIX H~~ Approved Capitation Rates
- X APPENDIX X-2 Modification Agreement Form ~~(to accompany modified appendices for changes in term or consideration on an existing period or for renewal periods.)~~

IN WITNESS WHEREOF, the parties hereto have executed or approved this AGREEMENT as of the dates appearing under their signatures.

CONTRACTOR

STATE AGENCY

By: _____

By: _____

Printed Name _____

Printed Name _____

Title: _____

Title: _____

Date: _____

Date: _____

State Agency Certification:

In addition to the acceptance of this contract, I also certify that original copies of this signature page will be attached to all other exact copies of this contract.

STATE OF NEW YORK)
) SS.:
County of)

On the _____ day of _____ in the year _____, before me, the undersigned, personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose names(s) is (are) subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their/ capacity(ies), and that by his/her/their signature(s) on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

Notary

Approved: _____

Approved: _____

ATTORNEY GENERAL

STATE COMPTROLLER

Title: _____

Title: _____

Date: _____

Date: _____

TABLE OF CONTENTS
PACE CONTRACT

Article I Term of Contract

Article II Approved PACE

Article III Obligations of the Contractor

- A. Enrollment
- B. Continuation of Enrollment
- C. Marketing and Enrollment Information
- D. Quality Assurance and Performance Improvement Program
- E. Duplicate CINs
- F. Contractor Responsibilities Related to Public Health
- G. Participant Ombudsman
- H. Requirements for the “Money Follows the Person” (MFP) Demonstration
- I. Contractor Responsibilities to Notify Enrollee of Termination, Service Area Changes and Network Changes
- ~~I.J.PACE Program Features Invalidated by Courts of Law, or by Changes to Federal Statutes, Regulations, or Approvals~~

Article IV Payment

- A. Capitation Payment
- B. Modification of Rates During Contract Period
- C. Rate Setting Methodology
- D. Payment of Capitation
- E. Denial of Capitation Payments
- F. Department Right to Recover Premiums
- G. Third Party Health Insurance Determination
- H. Other Insurance and Settlements
- I. Contractor Financial Liability
- J. Spenddown and Net Available Monthly Income
- K. No Recourse against Enrollees
- L. Notification Requirements to LDSS Regarding Enrollees
- M. Contractor’s Fiscal Solvency Requirements
- N. Prohibition on Payments to Institutions or Entities Located Outside of the United States
- O. Conversion Therapy

Article V Contractor Relationship with Subcontractors

- A. Subcontractor/Provider Relations
- B. Full Responsibility Retained
- C. Certification regarding Subcontractors
- D. Required Provisions
- E. List of Covered Services and Subcontractors
- F. Selective Contracting for Breast Cancer Surgery
- G. Never Events
- H. Provider Termination
- I. Recovery of Overpayments to Providers
- J. Optometry Services Provided by Article 28 Clinics Affiliated with the College of Optometry of the State University of New York.

- K. Dental Services Provided by Article 28 Clinics Operated by Academic Dental Centers not Participating in Contractor's Network.
- L. Home Care Services Worker Wage Parity Rules
- M. Fair Labor Standards Act

Article VI Records and Reporting Requirements

- A. Maintenance of Contractor Performance Records, Records Evidencing Enrollment Fraud and Documentation Concerning Duplicate CINS
- B. Maintenance of Financial Records and Statistical Data
- C. Access to Contractor Records
- D. Retention Periods
- E. Reporting Requirements
- F. Data Certification
- G. Notification of Changes in Reporting Due Dates Requirements or Formats
- H. Ownership and Related Information Disclosure
- I. Public Access to Reports
- J. Professional Discipline
- K. Certification Regarding Individuals Who Have Been Debarred or Suspended by Federal or State Government
- L. Conflict of Interest Disclosure
- M. OMIG's Right to Audit and Recover Overpayments Caused by Contractor Submission of Misstated Reports
- N. OMIG's Right to Audit and Recover Overpayments Which Were Caused by the Contractor's Misstated Encounter Data
- O. OMIG Compliance Review Authority
- P. Notification to Audit

Article VII Renewal or Termination of the contract

- A. Renewal
- B. Termination of the Contract by the Department
- C. Termination of the Contract by the Contractor
- D. Effect of Termination on New Enrollments
- E. Phase out; Transition

Article VIII Intermediate Sanctions and Requirements of Other Laws and Regulations

Article IX General Provisions

- A. Confidentiality
- B. Relationship of the Parties, Status of the Contractor
- C. Employment Practices
- D. Dispute Resolution
- E. Assignment
- F. Binding Effect
- G. Limitation of Benefits of this Contract
- H. Entire Contract
- I. Conflicting Provisions
- J. Modification
- K. Headings
- L. Pronouns
- M. Notices
- N. Partial Invalidity
- O. Force Majeure

- P. Survival
- Q. State Standard Appendix A
- R. Indemnification
- S. Environmental Compliance
- T. Energy Conservation
- U. Prohibition on Use of Federal Funds for Lobbying
- V. Waiver of Breach
- W. Choice of Law
- X. Executory Provision and Federal Funds
- Y. Renegotiation
- Z. Affirmative action
- AA. Omnibus Procurement Act of 1992
- BB. Fraud and Abuse
- CC. Nondiscrimination in Employment in Northern Ireland
- DD. Contract Insurance Requirement
- EE. Minority and Women Owned Business Policy Statement
- FF. Provisions Related to New York State Information Security Breach and Notification Act
- GG. Accessibility of State Agency Web-based Intranet and Internet Information and Applications
- HH. New York State Tax Law Section 5-a
- II. Provisions Related to New York State Procurement Lobbying Law
- JJ. Piggybacking
- KK. Lead Guidelines
- LL. Payment
- MM. M/WBE Utilization Plan for Subcontracting and Purchasing
- NN. On-going Responsibility
- OO. Language Access and Translation Requirements
- PP. High Cost High Need Risk Pool
- QQ. Modification to Benefit Package Services
- RR. Cultural and Linguistic Competence
- SS. Telehealth

Appendices

- Appendix A-1 PACE Program Agreement
- Appendix A Standard Clauses for New York State Contracts
- Appendix B New York State Department of Health Guidelines for Contractor Compliance with the Federal Americans with Disabilities Act
- Appendix C Certification Regarding Lobbying
- Appendix D ~~Standard Form LLL Disclosure of Lobbying Activities~~ Reserved
- Appendix E-1 Proof of Workers' Compensation Coverage
- Appendix E-2 Proof of Disability Insurance Coverage
- Appendix F Definitions
- Appendix G Conflict Free Evaluation and Enrollment Center (CFEEC)
- Appendix H Approved Capitation Rates
- Appendix X Modification Agreement Form

CONTRACT REGARDING PACE

This CONTRACT is hereby made by and between the State of New York Department of Health, hereinafter called the “Department” and the (*name of Contractor, with d/b/a as necessary*) hereinafter called the “Contractor” identified on the face page hereof.

WHEREAS, the Department is the single State agency charged with the responsibility for administration of the New York State Medical Assistance Program (Medicaid), Title 11 of Article 5 of the Social Services Law;

WHEREAS, the Contractor has been certified as a managed long term care plan pursuant to section 4403-f of the Public Health Law;

WHEREAS, the Contractor, the Centers for Medicare & Medicaid Services (CMS) and the Department have entered into a Program Agreement for a Program of All Inclusive Care for the Elderly (PACE) conformance with PACE legislation pursuant to Section 1934 of the Social Security Act and implementing regulations at 42 CFR 460; and

WHEREAS, the Contractor represents that the Contractor is able and willing to administer a PACE and the Department is desirous of having the Contractor administer a PACE.

NOW, THEREFORE, in consideration of the foregoing and of the covenants and agreements hereinafter set forth, the Parties hereto agree as follows:

ARTICLE I

TERM OF CONTRACT

Term: The Contract shall begin on and end on the dates identified on the face page hereof. The Contract shall be renewed or terminated as provided in Article VII.

ARTICLE II

APPROVED PACE

The Contractor agrees to operate in compliance with this Contract and with State law, regulation, and guidance issued by the Department to the extent they are consistent with federal PACE law and regulation and the PACE Program Agreement attached hereto as Appendix A-1 or as it may be amended. The Contractor agrees to abide by the instructions of the Department regarding the applicability of Article 44 of Public Health Law, and implementing Regulations.

ARTICLE III

OBLIGATIONS OF THE CONTRACTOR

A. Enrollment

1. The Contractor shall accept applications for enrollment from eligible Applicants in the order they are received without selecting among applications and without regard to the rate the Contractor will receive for such eligible person. The Contractor shall not discriminate against eligible Applicants on the basis of health status or need for health services. The Contractor shall accept enrollments of eligible Applicants without restriction and without regard to the eligible Applicant's age, sex (including gender identity or status of being transgender), race, creed, physical or mental disability (including gender dysphoria) developmental disability, national origin, sexual orientation, type of illness, or condition.

The Contractor agrees to transmit all information deemed necessary by the LDSS, or entity designated by the State, relative to its enrollment of the Applicant to the LDSS, or entity designated by the State, on a timely basis. This includes notification to the LDSS, or entity designated by the State, if Contractor is aware of the existence of duplicate Client Identification Numbers (CINs).

The Contractor shall determine eligibility for enrollment pursuant to requirements set forth in 42 CFR Part 460.150, including a determination that an applicant is expected to require at least one of the following Community Based Long Term Care Services (CBLTCS) covered by the plan for more than 120 days from the effective date of enrollment:

- Nursing services in the home or PACE Center;
- Therapies in the home or PACE Center;
- Private Duty Nursing;
- Home Health Aide Services in the home or PACE Center;

Personal Care Services in the home or PACE Center;
Adult Day Health Care; or
Other PACE Center Services.

2. Upon prior written notice to the Department, the Contractor may suspend enrollment of Applicants when the Contractor determines it has insufficient or inadequate resources to provide or arrange for the safety and effective delivery of Covered Services to additional Enrollees.
3. The Department shall have the right, upon notice to the LDSS, or other designated entity, to limit, suspend, or terminate enrollment activities by the Contractor and/or enrollment into the managed long term care plan upon 15 days written notice to the Contractor. The written notice shall specify the action(s) contemplated and the reason(s) for such action(s) and shall provide the Contractor with an opportunity to submit additional information that would support the conclusion that limitation, suspension or termination of enrollment activities or enrollment in the Contractor's managed long term care plan is unnecessary. Such reasons may include, but are not limited to substantial breach of a material provision of the Contract, the PACE Program Agreement, provider network insufficiency, financial distress of the Contractor and violation of federal or State laws governing delivery of services under the PACE Program Agreement, this Contract by the Contractor or its network providers. The Contractor shall have an opportunity to cure within the 15-day notice period. The Department reserves the right to suspend enrollment immediately in situations involving imminent danger to the health and safety of Enrollees. Nothing in this paragraph limits other remedies available to the Department under this Agreement.
4. The Department has the right to make further modification to the excluded populations as necessary to implement statewide Medicaid program initiatives, including Medicaid Redesign initiatives.

B. Continuation of Enrollment

The Contractor shall conduct an annual reassessment in accordance with 42 CFR Part 460.104(c)(2), which shall include the completion of the patient assessment tool specified by the Department. This assessment must be conducted at least annually, no earlier than 30 days prior to the anniversary date of the Participant's enrollment into the PACE program.

Pursuant to the annual recertification requirement at 42 CFR Section 460.160(b) the contractor will certify continued need for nursing facility level of care using the patient assessment tool and any additional information required to make the determination. The contractor will submit results of the annual patient assessment to the Department in accordance with established reporting guidelines.

If an Enrollee is no longer eligible for nursing home level of care using the assessment tool prescribed by the Department, in accordance with 42 CFR Section 460.160(b)(2) , the LDSS, or entity designated by the State, will determine continued eligibility using the criteria articulated in Appendix E of the PACE Program Agreement. The contractor will provide the Local Department of Social Services, or entity designated by the State, the patient assessment tool specified by the Department completed at the time of the annual reassessment, the results of the assessment and recommendations regarding continued eligibility for enrollment. This information will be provided within 5 business days of the completion of the annual reassessment.

Disagreements between the Contractor and the LDSS, or entity designated by the State, regarding the continued eligibility criteria shall be resolved in accordance with the dispute resolution process determined by the State.

C. Marketing and Enrollee Information

1. The Contractor shall submit for approval to the Department all marketing information and materials and its marketing plan including revisions and updates prior to implementation or distribution.
2. The Contractor shall comply with all requests from the Department for periodic reports on the performance of its responsibilities pursuant to this section. The Contractor shall submit these reports within thirty (30) days of receiving the requests from the Department.

D. Quality Assurance and Performance Improvement Program

The Contractor must have a Department approved quality assurance program. The Contractor agrees to submit any proposed material revisions to the approved quality plan for Department approval prior to implementation of the revised plan.

E. Duplicate CINs

The Contractor, within five (5) business days of identifying cases where a person may be enrolled in the Contractor’s PACE plan under more than one Client Identification Number (CIN), or has knowledge of an Enrollee with more than one active CIN, must convey that information in writing to the LDSS, or entity designated by the State.

Notwithstanding the foregoing, the SDOH always has the right to recover premiums paid for persons who have concurrent enrollment in one or more managed care products under more than one Client Identification Number (CIN).

F. Contractor Responsibilities Related to Public Health

1. The Contractor shall provide the State with existing information as requested to facilitate epidemiological investigations.
2. The Contractor shall make reasonable efforts to assure timely and accurate compliance by Providers with public health reporting requirements related to communicable diseases and conditions mandated in Article 21 of the NYS Public Health Law and, for Contractors operating in New York City, the New York City Health Code (24 RCNY §§ 11.03 – 11.07).
3. The Contractor shall make reasonable efforts to assure timely and accurate compliance by Providers with other mandated reporting requirements.
4. [Special Contracting Provisions in Response to the Novel Coronavirus \(COVID-19\) Pandemic](#)

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- a. Notwithstanding the requirements of all sections and appendices of this Agreement, other than Appendix A, requirements specified in this section shall take precedence over all other requirements in this Agreement.
- b. Unless otherwise specified, for the period beginning March 7, 2020, and continuing until such dates as determined under paragraph (g) of this section, the Contractor shall comply with, and establish policies and procedures that expeditiously implement, all applicable requirements and Medicaid guidance issued in response to the COVID-19 disaster emergency, including but not limited to:
- i. State-mandated reimbursement rates appropriately approved under State or Federal authority that the Contractor pays to Participating and Non-Participating Providers for services delivered to Enrollees. Specifically:
- A. absent existing state mandated rates or negotiated rates for telehealth/telephonic services, the Contractor shall reimburse Participating Providers at the same rate that would be reimbursed for providing the same service via a face-to-face encounter.
- B. the Contractor shall not limit Enrollee access to telehealth/telephonic services to solely the Contractor's telehealth providers and shall cover appropriate telehealth/telephonic services provided by other Participating Providers.
- C. the Contractor shall pay legally authorized Participating Providers no less than the Medicaid fee-for-service administration fee for COVID-19 vaccinations that are administered to Enrollees. The Contractor shall offer to contract with legally authorized Non-Participating Providers that seek payment for the administration of the COVID-19 vaccine. Unless otherwise agreed by the parties, such contract shall be limited to reimbursement for the administration of the COVID-19 vaccine.
- ii. Effective March 1, 2020, enrollment and disenrollment requirements detailed below, including but not limited to the suspension of such requirements, and Department-issued retroactive enrollment directives. Specifically:
- A. the Contractor shall not involuntarily disenroll an Enrollee for any reason other than:
- death of the Enrollee;
 - Enrollee is no longer residing in New York State; or
 - at the written direction of the SDOH.
- B. an Enrollee who was involuntarily disenrolled after March 18, 2020 for reasons other than that provided under Article III(F)(4)(b)(ii)(A) of this Agreement, shall be permitted to re-enroll in an available and appropriate MCO retroactively, to the extent necessary to maintain continuous Enrollment until such date as determined in paragraph (g) below.

- C. Notwithstanding the provisions of Article III(F)(4)(b)(ii) above, the Contractor shall coordinate benefits in accordance with Article IV(G)(1) of this Agreement. Medicaid shall remain the payor of last resort.
- iii. The credentialing of temporary provisional providers and the re-credentialing Participating Providers, specifically:
- A. effective March 1, 2020, the Contractor may credential and contract with providers who have been enrolled in the New York State Medicaid Program as temporary provisional providers under the authority of the CMS Section 1135 Waiver for New York State. After the time period described in paragraph (g) below, such providers must complete a full enrollment with the Medicaid Program in order to remain in the Contractor's network, and;
- B. the Contractor shall extend the credentialing timeframe in accordance with Article V(D)(2), V(D)(4)(g) and 10 NYCRR 98-1.12 for all Participating Providers whose credentialing period is set to expire during the time period described in paragraph (g) below.
- iv. Effective March 20, 2020, as directed by DOH in consultation with DFS, suspension of utilization review and prior authorization requirements for home health services following an inpatient hospital admission.
- v. The allowance of alternative methods, modalities, and settings for assessing, approving and delivering Benefit Package services and providing care management, including but not limited to the delivery of such services by way of telehealth or telephonic means.
- A. Effective March 18, 2020, a verbal order from a physician shall be sufficient to initiate assessment for and subsequent authorization of PCS or CDPAS; the Contractor must document the date the physician provided the verbal order in the Enrollee's PCSP and receive the standard physician order within 120 days of the date the verbal order is issued.
- B. Effective March 18, 2020, for Enrollees in receipt of LTSS, requirements for periodic reassessments at least every six months shall be suspended and the Contractor shall authorize the LTSS at the current level and quantity in 90 day periods until resumption of periodic assessments. Upon request, the Contractor may conduct assessment and authorize additional or increased services if medically necessary.
- C. Effective April 8, 2020, the Contractor may extend issuance of an authorization decision on an initial or increase request for community based long term care services or supports up to two times for up to 90 days per extension provided the plan is unable to authorize the services sought due to an inability to adequately complete an assessment, provided that during any such extension the Contractor shall authorize the services sought under a temporary plan of care.

- vi. Effective April 23, 2020, to implement procedures for Contractor to reach out to enrollees to enable enrollees to express their intent to voluntarily implement changes to their plan of care.
- c. Effective March 1, 2020, where enrollment is authorized under paragraph (b)(ii) above, recovery of plan premium payments shall not be made where SDOH finds that an enrollee was for the entire applicable payment month(s):
 - i. Simultaneously enrolled or in receipt of covered services through any government insurance programs;
 - ii. Simultaneously enrolled or in receipt of covered services through another product offered by Contractor (or a parent, subsidiary, or related entity); or
 - iii. Upon written direction of the SDOH, otherwise ineligible to be enrolled in a PACE plan pursuant to this Agreement, or State or federal law.
- d. Effective March 18, 2020, the Department may modify timeframes specified in Article IV(D)(1) of this Agreement for the provision of a Roster and/or 834 File to the Contractor, and may modify the method of notification of Enrollments to effectuate Enrollments as authorized under paragraph (b)(ii) above.
- e. Effective March 18, 2020, in accordance with the Families First Coronavirus Response Act, the Contractor shall, without impositions of any cost sharing, cover testing, services and treatments— including vaccines, specialized equipment, and therapies— related to COVID-19.
- f. Effective March 7, 2020, the Contractor shall develop and implement a COVID-19 preparedness strategy, drawing from and incorporating into the Contractor’s internal emergency preparedness plan, that includes, at a minimum, the following components:
 - i. An emergency preparedness plan that ensures infrastructure stability and business continuity for care to be delivered to Enrollees in the event of the further spread of COVID-19 in New York.
 - ii. Strategies that facilitate prompt access to all needed Benefit Package services for the detection and treatment of COVID-19, including but not limited to:
 - A. system enhancements that will permit payment to laboratories that are approved to provide COVID-19 testing;
 - B. processes that ensure prompt Enrollee access to all Benefit Package services relevant to COVID-19 care, including, as applicable: outpatient services, telehealth services, inpatient services, emergency services, screening and diagnostic tests, medications, treatments, and emergency transportation services; and
 - C. evaluation and removal of preauthorization requirements that may delay access to medically necessary treatment for COVID-19.

- iii. Processes to provide information and resources to Enrollees on how to protect themselves and minimize transmission of the virus and assist Enrollees with understanding how and when to access Benefit Package services for COVID-19 care.
 - iv. Processes to provide guidance and education to promptly answer all provider questions and concerns about relevant COVID-19 covered services and to ensure that providers deliver all necessary care to Enrollees.
 - v. Processes to provide prompt Enrollee access to providers appropriately trained in COVID-19 care, including out-of-network access in the event of the unavailability of an appropriate Participating Provider to treat an Enrollee.
 - vi. In accordance with the requirements of Article VI, sections C and D of this Agreement, the Contractor shall preserve and maintain records relating to its plan and process for its COVID-19 preparedness plan and furnish such records to the State upon request.
- g. The provisions of this section shall remain in effect in accordance with the following:
- i. paragraphs (b)(i), (b)(iii), (b)(v)(A), and (b)(vi) shall remain in effect until the expiration of the state disaster emergency declared in Executive Order 202 and subsequent orders or any extensions thereto, or as otherwise provided in such orders, or until such notice from the SDOH prior to the expiration of the state disaster emergency.
 - ii. paragraphs (b)(ii), (c), (d) and (e) shall remain in effect until the last day of the month in which the federal emergency period ends or, if necessary to ensure enhanced federal financial participation under section 6008 of the Families First Corona Virus Response Act (FFCRA), the last day of the calendar quarter in which the last day of such emergency period occurs, or such other date as may be required or necessary to ensure enhanced federal financial participation pursuant to federal law or regulation, or until such notice by the SDOH prior to the end of the federal emergency period.
 - iii. paragraph (b)(iv) shall remain in effect for the time periods specified in Circulars issued by the Department of Financial Services or other applicable notice issued by either the Department of Financial Services or the SDOH as provided for in such notice or as directed by the SDOH, but no later than the expiration of the state disaster emergency declared in Executive Order 202 and subsequent orders or any extensions thereto, or as otherwise provided in such orders.
 - iv. paragraph (b)(v)(B) and (b)(v)(C) shall remain in effect until the expiration of the state disaster emergency declared in Executive Order 202 and subsequent orders or any extensions thereto, or as otherwise provided in such orders, or until such notice from the SDOH prior to the expiration of the state disaster emergency, or until the termination of the federal public health emergency and any extensions thereto.
- h.

i. Except as specifically provided for herein, nothing in this section shall be construed to limit the authority of SDOH, OMIG, OAG or OSC to audit and investigate cases of fraud, waste and abuse, and to take any action authorized by law or this Agreement.

i-ii. The provisions of Article III(F)(4) of this Agreement notwithstanding, nothing shall prohibit any investigation or action of any acts of fraud, willful or intentional criminal conduct, gross negligence, reckless misconduct, or intentional infliction of harm.

G. Participant Ombudsman

The Contractor will cooperate with, and may not inhibit, the Participant Ombudsman in the exercise of its duties.

1. The Participant Ombudsman is an independent organization that provides free ombudsman services to long term care recipients in the state of New York. These services include, but are not necessarily limited to:
 - a. providing pre-enrollment support, such as unbiased health plan choice counseling and general program-related information,
 - b. compiling enrollee complaints and concerns about enrollment, access to services, and other related matters,
 - c. helping enrollees understand the fair hearing, grievance and appeal rights and processes within the health plan and at the state level, and assisting them through the process if needed/requested, including making requests of plans and providers for records, and
 - d. informing plans and providers about community-based resources and supports that can be linked with covered plan benefits.
2. The Contractor must include information about the Participant Ombudsman program, including its purpose, scope and nature of its services, and contact information, in the PACE Plan enrollment agreement, enrollee materials, action and adverse determination notices, and all grievance or appeal notices or communications.
3. The Contractor must also, upon request, provide the Participant Ombudsman entity with a current list of Participating Providers in Contractor's PACE Plan.

H. Requirements for the "Money Follows the Person" (MFP) Demonstration

In order to comply with MFP requirements PACE plans must:

1. Include the "MFP Attestation for Enrollment Agreement" in the plan's Enrollment Agreement; and
2. Include the following language describing MFP in the plan's Member Handbook:
 - a. Money Follows the Person (MFP)/Open Doors

This section will explain the services and supports that are available through *Money Follows the Person (MFP)/Open Doors*. *MFP/Open Doors* is a program that can help Enrollees move from a nursing home back into their home or residence in the community. Enrollees may qualify for MFP if they:

- Have lived in a nursing home for three months or longer
- Have health needs that can be met through services in their community

MFP/Open Doors has people, called Transition Specialists and Peers, who can meet with enrollees in the nursing home and talk with them about moving back to the community. Transition Specialists and Peers are different from Care Managers and Discharge Planners. They can help Enrollees by:

- Giving them information about services and supports in the community
- Finding services offered in the community to help Enrollees be independent
- Visiting or calling Enrollees after they move to make sure that they have what they need at home.

For more information about *MFP/Open Doors*, or to set up a visit from a Transition Specialist or Peer, please call the New York Association on Independent Living at 1-844-454-7108, or email mfp@health.ny.gov. You can also visit *MFP/Open Doors* on the web at www.health.ny.gov/mfp or www.ilny.org.

I. Contractor Responsibilities to Notify Enrollee of Termination, Service Area Changes and Network Changes

With prior notice to and approval of the Department, the Contractor shall inform each Enrollee in writing of any withdrawal by the Contractor from the PACE MLTC Program pursuant to Article VII, Section E of this Contract, withdrawal from the service area encompassing the Enrollee's zip code, and/or significant changes to the Contractor's Participating Provider network, except that the Contractor need not notify Enrollees who will not be affected by such changes.

The Contractor shall provide the notifications within the timeframes specified by the Department, and shall obtain the prior approval of the notification from the Department.

J. PACE Program Features Invalidated by Courts of Law, or by Changes to Federal Statutes, Regulations, or Approvals

Should any part of the scope of work under this Agreement relate to a program or activity of the State Medicaid Program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), the Contractor shall do no work on that part after the effective date of the loss of authority. The SDOH shall adjust Capitation Rates to remove costs that are specific to any program or activity that is no longer authorized by law. If the Contractor works on a program or activity no longer authorized by law after the date the legal authority for the work ends, the Contractor shall not be paid for that work. If the state paid the Contractor in advance to work on a no-longer-authorized program or activity and under the terms of this Agreement

the work was to be performed after the date the legal authority ended, the payment for that work should be returned to the state in accordance with direction from SDOH. However, if the Contractor worked on a program or activity prior to the date legal authority ended for that program or activity, and the state included the cost of performing that work in its payments to the Contractor, the Contractor may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

ARTICLE IV

PAYMENT

A. Capitation Payments

Compensation to the Contractor shall consist of a monthly capitation payment for each Enrollee.

1. Rates shall be determined in compliance with 42 CFR 460.182 (b) (1), and section 4403-f of New York Public Health Law.
2. The monthly Capitation Rates are set forth in the PACE Program Agreement that is attached hereto as Appendix A-1 and is incorporated herein.
3. The monthly capitation payment to the Contractor shall constitute full and complete payments to the Contractor for all services that the Contractor provides pursuant to this Contract.
4. Capitation Rates shall remain in effect until such time as modifications are made pursuant to Sections B and C of this Article.

B. Modification of Rates during Contract Period

1. Any technical modification to Capitation Rates, during the term of the Contract as agreed to by the Contractor, including but not limited to changes in premium groups, shall be deemed incorporated into this Contract without further action by the parties upon approval of such modifications by the Department.
2. Any other modification to Capitation Rates, as agreed to by the Department and the Contractor during the term of the Agreement shall be deemed incorporated into this Contract without further action by the parties upon approval of such modifications by the Department and the State Division of the Budget and DHHS as of the effective date of the modified Capitation Rates as established by the Department and approved by the State Division of Budget and DHHS.
3. In the event that the Department and the Contractor fail to reach agreement on modifications to the monthly Capitation Rates, the Department will provide formal written notice to the Contractor of the amount and effective date of the modified Capitation Rates approved by the State Division of the Budget and DHHS. The Contractor shall have the option of terminating this Contract, if such approved modified Capitation Rates are not acceptable. In such case, the Contractor shall give written notice to the Department and the Local Department of Social Services, or entity designated by the State, within thirty (30) days of the date of the formal

written notice of the modified Capitation Rates from the Department specifying the reasons for and effective date of termination. The effective date of termination shall be ninety (90) days from the date of the Contractor's written notice, unless the Department determines that an orderly disenrollment to Medicaid fee-for-service or transfer to another managed long-term care plan can be accomplished in fewer days. The terms and conditions in the Contractor's phase-out plan specified in Article IV must be accomplished prior to termination. During the period commencing with the effective date of the Department's modified Capitation Rates through the effective date of termination of the Contract, the Contractor shall have the option of continuing to receive capitation payments at the expired Capitation Rates or at the modified Capitation Rates approved by the Department and the State Division of the Budget for the rate period.

4. If the Contractor fails to exercise its right to terminate in accordance with this Section, then the modified Capitation Rates, approved by the Department and the State Division of the Budget, shall be deemed incorporated into this Contract without further action by the parties as of the effective date of the modified Capitation Rates as established by the Department, and approved by the State Division of the Budget.

C. Rate-Setting Methodology

1. Capitation Rates shall be determined prospectively and shall not be retroactively adjusted to reflect actual Medicaid fee-for-service data or Contractor experience for the time period covered by the rates. Capitation rates shall be certified to be actuarially sound in accordance with 42 CFR § 460.182.
2. Notwithstanding the provisions set forth in Section C (1.) above, the Department reserves the right to terminate this Agreement, in its entirety pursuant to Article VII. Section B. of this Contract, upon determination by the Department that the aggregate monthly Capitation Rates are not cost effective pursuant to subsection 4403-f of Public Health Law.

D. Payment of Capitation

1. The monthly capitation payment for each Enrollee is due to the Contractor from the Effective Date of Enrollment until the Effective Date of Disenrollment of the Enrollee or termination of this Contract, whichever occurs first. The Contractor shall receive a full month's capitation payment for the month in which disenrollment occurs. The Roster generated by the Department, along with any modification communicated electronically or in writing by the Department, the LDSS, or entity designated by the State, prior to the end of the month in which the Roster is generated, shall be the enrollment list for purposes of eMedNY premium billing and payment. The Contractor, the LDSS, or entity designated by the State may develop protocols for the purpose of resolving Roster discrepancies that remain unresolved beyond the end of the month.
2. Upon receipt by the Fiscal Agent of a properly completed claim for monthly capitation payments submitted by the Contractor pursuant to this Contract, the Fiscal Agent will promptly process such claim for payment through eMedNY and use its best efforts to complete such processing within thirty (30) business days from date of receipt of the claim by the Fiscal Agent. Processing of Contractor claims shall be in compliance with the requirements of 42 CFR 447.45. The Fiscal Agent will also use its best efforts to resolve any billing problem relating to the Contractor's claims as soon as possible. In accordance with Section 41 of the State Finance Law, the State, LDSS, or entity designated by the State shall not have any liability under this

Contract to the Contractor or anyone else beyond funds appropriated and available for payment of Medical Assistance care, services and supplies.

E. Denial of Capitation Payments

In the event that CMS denies payment for new or existing Enrollees under 42 CFR 460.42 or 460.48 or under other applicable federal statutes and regulations, the Department will deny capitation payments to the Contractor for the same Enrollees for the period of time for which CMS denies payment. If the Contractor prevails during an appeal and CMS restores payment for new or existing Enrollees, then the Department will also restore capitation payments to the Contractor.

F. Department Right to Recover Premiums

The parties acknowledge and accept that the Department has a right to recover premiums paid to the Contractor for Enrollees listed on the monthly Roster who are later determined, for the entire applicable payment month, to have been incarcerated; to have moved out of the Contractor's service area; to have been out of the service area for more than 30 consecutive days without approval from the Department; to no longer meet the State Medicaid nursing facility level of care based on the annual recertification requirements in 42 CFR Section 460.160(b) and did not provide the results of the reassessment to the LDSS, or entity designated by the State, within five days of completion as stated in Article III, paragraph B; or to have died. The Department has the right to recover premiums from the Contractor in instances where the Enrollee was inappropriately enrolled into the plan with a retroactive effective date, or when the enrollment period was retroactively deleted. Additionally, the Department may recover premiums in all cases where no services are provided during the applicable period, unless the Contractor demonstrated that it was at risk for provision of medical services for any portion of the payment period. Instances where the Contractor is not at risk include, but are not necessarily limited to, circumstances where the enrollee was not eligible for services, or where providers in fact refused or failed to render any services. Notwithstanding the foregoing, the Department always has the right to recover duplicate premiums paid for persons enrolled under more than one Client Identification Number (CIN) in the Contractor's PACE plan whether or not the Contractor has made payments to providers. All recoveries will be made pursuant to Guidelines developed by the state.

The Contractor must also notify the Department and must return any and all payments made to Contractor as a result of a duplicate CIN to the Department within five (5) business days and in a manner determined by the Department.

G. Third Party Health Insurance Determination

1. Point of Service (POS)

The Contractor will make diligent efforts to determine whether Enrollees have third party health insurance (TPHI). The LDSS is also responsible for making diligent efforts to determine if Enrollees have TPHI and to maintain third party information on the WMS/eMedNY Third Party Resource System. If TPHI coverage is known at the POS, the Plan shall use the TPHI information to coordinate benefits (e.g., alert the provider and ask them to bill the TPHI that should be primary to the Plan).

The Contractor shall make good faith efforts to coordinate benefits and must inform the LDSS of any known changes in status of TPHI insurance eligibility within five (5) business days of

learning of a change in TPHI. The Contractor may use the Roster as one method to determine TPHI information.

2. Post Payment and Retroactive Recovery

The State, and/or its vendor, will also be vested with the responsibility to collect any reimbursement for Benefit Package services obtained from TPHI. In no instances may an Enrollee be held responsible for disputes over these recoveries. A recovery shall not exceed the encounter data paid claim amount.

The State will continue to identify available TPHI and post this information to the eMedNY System. The TPHI information will appear on the Contractor's next roster and TPHI file. The Contractor will have six months from the later of the date the TPHI has been posted (eMedNY transaction date) or the Contractor's claim payment date to pursue any recoveries for medical services. All recoveries outside this period will be pursued by the State.

For State-initiated and State-identified recoveries, the State will direct providers to refund the State directly. In those instances where the provider adjusted the recovery to the Contractor in error, the Contractor will refund the adjusted recovery to the State.

3. TPHI Reporting

The Contractor shall report TPHI activities through the Medicaid Encounter Data System (MEDS) and Medicaid Managed Care Operating Report (MMCOR) in accordance with instructions provided by SDOH. To prevent duplicative efforts, the Contractor shall, on a quarterly basis, share claim specific TPHI disposition (paid, denied, or recovered) information with the State. If no information is received from the Contractor, the State will assume there are not retroactive recoveries being pursued by the Contractor and will initiate recovery processing.

H. Other Insurance and Settlements

The Contractor is not allowed to pursue cost recovery against personal injury awards or settlements that the Enrollee has received. Any recovery against these resources is to be pursued by the Medicaid program and the Contractor cannot take action to collect these funds. Pursuit of Worker's Compensation benefits and No-fault Insurance by the Contractor is authorized, to the extent that they cover expenses incurred by the Contractor

I. Contractor Financial Liability

The Contractor shall not be financially liable for any services rendered to an Enrollee prior to his or her Effective Date of Enrollment or subsequent to disenrollment unless the Enrollee is admitted to a hospital prior to the Effective Date of Disenrollment and is not discharged from the hospital until after the Effective Date of Disenrollment, in which case the Contractor is responsible for the entire hospital claim.

J. Spenddown and Net Available Monthly Income

Capitation rates are adjusted to exclude Enrollee Spenddown and NAMI as determined by the Local Department of Social Services. The surplus amount (spend down or NAMI amount) to be billed to

an Enrollee by the Contractor must be the amount for which the Enrollee is responsible as determined by the LDSS. The method of collection of NAMI is subject to the terms of Contractor's agreement with a network Nursing Facility. The Contractor's inability to collect funds from Enrollees will not change the plan's Spenddown or NAMI adjustment. The Contractor shall report the gross amount of Spenddown and NAMI for each Enrollee in accordance with the timeframes and in the format prescribed by the Department.

The Contractor shall assist Enrollees with the renewal of their Medicaid benefits.

K. No Recourse Against Enrollees.

Except for the rates and payments provided for in this Contract, the Contractor hereby agrees that in no event, including but not limited to nonpayment by the Medicaid agency, insolvency of the Contractor, loss of funding for this program, or breach of this Contract, shall the Contractor or a Subcontractor bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against any Enrollee or person acting on his behalf for Covered Services furnished in accordance with this Contract.

This Section K. shall not prohibit the Contractor or the Subcontractors as specified in their agreements from billing for and collecting any applicable surplus amounts, Net Available Monthly Income (NAMI), commercial insurance, worker's compensation benefits, no-fault insurance, and coordination of benefit amounts. This Section J. supersedes any oral or written contrary agreement now existing or hereinafter entered into between the Contractor and any Enrollee or persons acting on his behalf. This provision shall survive termination of this Contract for any reason.

L. Notification Requirements to LDSS Regarding Enrollees

The Contractor agrees to notify the LDSS in writing prior to admission of an Enrollee to a nursing facility, to allow Medicaid eligibility to be redetermined using institutional eligibility rules. The notification will include the Enrollee's name, Medicaid number, nursing facility name and other information as directed by the Department. If such an Enrollee is determined by the LDSS to be ineligible for Medicaid nursing facility services, the LDSS shall notify the Contractor of such determination.

M. Contractor's Fiscal Solvency Requirements

The Contractor, for the duration of this Agreement, shall remain in compliance with all applicable state requirements for financial solvency for MCOs participating in the Medicaid Program. The Contractor shall continue to be financially responsible as defined in PHL §4403(1)(c) and shall comply with the contingent reserve fund and escrow deposit requirements of 10 NYCRR Part 98 and must meet minimum net worth requirements established by the Department and the New York State Department of Financial Services. The Contractor shall make provision, satisfactory to the Department, for protections for the Department, LDSS and the Enrollees in the event of Contractor or subcontractor insolvency, including but not limited to, hold harmless and continuation of treatment provisions in all provider agreements which protect the Department, LDSSs and Enrollees from costs of treatment and assures continued access to care for Enrollees.

N. Prohibition on Payments to Institutions or Entities Located Outside of the United States

Effective no later than June 1, 2011, the Contractor is prohibited under Section 6505 of the federal Affordable Care Act, which amends Section 1902(a) of the Social Security Act, from making payments for Medicaid covered items or services to any financial institution or entity, such as provider bank accounts or business agents, located outside of the United States, District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands and American Samoa.

O. Conversion Therapy

All subcontracts, including Provider Agreements entered into by the Contractor to provide program services under this Contract shall contain provisions specifying that the Contractor will not provide reimbursement for Conversion Therapy.

ARTICLE V

CONTRACTOR RELATIONSHIP WITH PROVIDERS

A. Provider Relations.

The Contractor is responsible to provide the following provider Services:

- (i). assisting providers with prior authorization and referral protocols;
- (ii). assisting providers with claims payment procedures;
- (iii). fielding and responding to provider questions and complaints;
- (iv). orientation of providers to program goals; and
- (v). provider training to improve integrations and coordination of care.

B. Full responsibility retained.

1. Notwithstanding any relationship(s) that the Contractor may have with Providers, the Contractor maintains full responsibility for adhering to and otherwise fully complying with all applicable laws, regulations and implementing guidelines, this Contract, the PACE Program Agreement, 42 CFR 460 and the instructions of the Department.
2. The Contractor oversees and is accountable to the Department for all functions and responsibilities that are described in this Contract and the PACE Program Agreement.
3. The Contractor may only delegate activities or functions to a Provider in a manner consistent with requirements set forth in this Contract, the PACE Program Agreement and 42 CFR 460.
4. The Contractor may only delegate management responsibilities as defined by State regulation by means of a Department approved management services agreement. Both the proposed management services agreement and the proposed management entity must be approved by the Department pursuant to the provisions of 10 NYCRR 98-1.11, and in compliance with the Management Services Agreement Guidelines issued by the Department, before any such agreement may be implemented.

C. Certification regarding Providers.

The Contractor shall certify to the Department annually, at a date to be specified by the Department, and/or upon the Department's request, that the Contractor has not entered into a relationship, agreement, or Provider Agreement for any activity or function under this Contract with a person, provider or entity who has been debarred or suspended from participation by either the federal or State governments in programs administered pursuant to Titles XVIII and XIX of the Social Security Act.

D. Required provisions.

1. The Contractor shall enter into contracts only with Providers who are in compliance with all applicable State and federal licensing, certification, and other requirements, who are generally regarded as having a good reputation and who have demonstrated capacity to perform the needed contracted services. All Provider contracts must meet the requirements of this Contract and applicable State and federal laws and regulations.
2. Provider contracts shall require the approval of the Department as set forth in Public Health Law Section 4402 and in 10 NYCRR Part 98, and be consistent with guidelines issued by the Department.
3. All Provider contracts must meet applicable requirements, including but not limited to, 42 CFR 460, the PACE Program Agreement, 10 NYCRR Part 98 and this Contract.
4. All contracts with providers of covered services(including management agreements, if applicable) shall include the following provisions:
 - (a). Any services or other activities performed by a provider in accordance with a contract or written agreement between provider and the Contractor will be consistent and comply with the Contractor's contractual obligations under this Contract and the PACE Program Agreement.
 - (b). A provision that the Contractor will provide, no less than thirty (30) days prior to implementation, any new rules or policies and procedures regarding quality improvement, member appeals and grievances and provider credentialing, or any changed thereto, to a provider of covered services.
 - (c). No provision of the provider contract is to be construed as contrary to the provisions of Article 44 of Public Health Law and implementing regulations to the extent that it does not conflict with 42 CFR 460.
 - (d). Specific delegated activities and reporting responsibilities, including the amount, duration and scope of services to be provided, and reasonable timeframes for submission of claims to the Contractor.
 - (e). Satisfactory remedies, including termination of a provider contract when the Department or the Contractor determines that such parties have not performed adequately which includes but is not limited to egregious patient harm, significant substantiated complaints, submitting claims to the plan for services not delivered, and refusal to participate in the plan's quality improvement program.
 - (f). Provision for ongoing monitoring of the provider's compliance with the provider contract by the Contractor. Such monitoring shall specify requirements for corrective action, revocation

of the provider contract or imposing sanctions if the provider's performance is inadequate.

(g). Specification that either:

- (i.) the credentials of affiliated professionals or other health care providers will be reviewed directly by the Contractor; or
- (ii.) the credentialing process of the provider will be reviewed and approved by the Contractor and the Contractor must audit the credentialing process on an ongoing basis.

(h). A procedure for the resolution of disputes between the Contractor and its providers or related entities. Any and all such disputes shall be resolved using the Department's interpretation of the terms and provisions of this Contract, and portions of provider contracts executed hereunder that relate to services pursuant to this Contract. If a provider contract provides for arbitration or mediation, it shall expressly acknowledge that the Commissioner of the Department of Health is not bound by arbitration or mediation decisions. Arbitration or mediation must occur within New York State, and the provider contract shall provide that the Commissioner will be given notice of all issues going to arbitration or mediation, and copies of all decisions.

(i). A provision specifying how the provider shall participate in and comply with the Contractor's quality assurance and utilization review programs, the Contractor's Enrollee grievance and appeals procedures, and the monitoring and evaluation of the Contractor's PACE Program.

(j). A provision specifying how the provider will insure that pertinent contracts, books, documents, papers and records of their operations are available, to the Department, HHS, Comptroller of the State of New York, Comptroller General of the United States and/or their respective designated representatives, for inspection, evaluation and audit, through ten (10) years from the final date of the provider contract, or from the date of completion of any audit, or pursuant to the timeframes established in 42 CFR 460, whichever is later.

5. The Contractor agrees to comply with Section 3224-a of State Insurance Law pertaining to prompt payment to providers of covered services.
6. Nothing contained in this Agreement between SDOH and the Contractor shall create any contractual relationship between the Department and any provider subcontractor of the Contractor, including but not limited to Participating Providers, Non-Participating Providers, and third parties. Nothing in this paragraph shall be construed to limit the authority of the New York State Office of the Attorney General to commence any action pursuant to 31U.S.C. § 3729 et seq., State Finance Law § 187 et seq., Social Services Law § 145-b or other New York or Federal statutes, regulations or rules.

E. List of Covered Services and Providers

1. The Department may request additional information about providers or related entities in the network, as required.
2. Provider contracts and material amendments thereto shall require the approval of the

Department as set forth in Public Health Law Section 4402 and 10 NYCRR Part 98, and consistent with guidelines issued by the Department.

3. Any addition to or deletion from the network of providers or related entities shall be promptly communicated in writing to the Department by the Contractor, on a quarterly basis.

F. Selective Contracting for Breast Cancer Surgery

The Contractor agrees to provide breast cancer surgery only at hospitals and ambulatory surgery centers designated as meeting high volume thresholds as determined by the Department. The Department will update the list of eligible facilities annually.

G. Never Events

1. The Contractor is required to develop claims and payment policies and procedures regarding “never events” or “hospital acquired conditions” that are consistent with the Medicaid program. Specifically this includes:
 - (a) Development of the capacity for claims systems to recognize the presence or absence of valid “present on admission” (POA) indicators for each inpatient diagnosis, using codes as described by the Centers for Medicare and Medicaid Services for Medicare, no later than April 30, 2010;
 - (b) Development of the capacity for claims systems to reject/deny claims that do not have valid POA indicators (corrected claims can be resubmitted), with the initiation of this edit no later than April 30, 2010;
 - (c) Development of policies and procedures that will reject or modify any inpatient charges resulting from any “never event” or “hospital acquired condition” (pursuant to the current list of implemented items provided on the Department of Health and HCS websites), no later than April 30, 2010;
 - i. The methodology for claims adjustment shall be consistent with current Medicaid program guidance provided on the Department of Health and HCS websites.
 - ii. In the event that payment for inpatient claims is not based on DRGs, the Contractor shall develop a system that is equivalent in result to the methodology developed by Medicaid program.
 - (d) Development of an audit or review capacity to ensure that claims are submitted accurately and adjudicated consistent with this policy.
2. The Contractor is required to submit inpatient claims with valid POA fields to MEDS III or its successor system.

H. Provider Termination.

1. The Contractor shall comply with the requirements of Section 4406-d of Public Health Law regarding health care professional terminations.

2. The Contractor shall provide the Department at least sixty (60) days notice prior to termination of any provider contract, the termination of which would preclude an Enrollee's access to a Covered Service by provider type under this Contract, and specify how services previously furnished by the provider will be provided. In the event a contract is terminated on less than sixty (60) days notice, the Contractor shall notify the Department immediately but in no event more than seventy-two (72) hours after notice of termination is issued.
 - a) The Contractor shall notify the Department of any notice of termination or non-renewal of an IPA or institutional network Provider Agreement, or medical group Provider Agreement that serves five percent or more of the enrolled population in a LDSS and/or when the termination or non-renewal of the medical group provider will leave fewer than two Participating Providers of that type within the LDSS, unless immediate termination of the Provider Agreement is justified. The notice shall include an impact analysis of the termination or non-renewal with regard to Enrollee access to care.
 - b) The Contractor shall provide the notification required in (a) above to the Department if the Contractor and the Participating Providers have failed to execute a renewal Provider Agreement forty-five (45) days prior to the expiration of the current Provider Agreement.
 - c) In addition to the notification required in (a) above, the Contractor shall submit a contingency plan to the Department, at least forty-five (45) days prior to the termination or expiration of the Provider Agreement, identifying the number of Enrollees affected by the potential withdrawal of the provider from the Contractor's network and specifying how services previously furnished by the Participating Provider will be provided in the event of its withdrawal from the Contractor's network. If the Participating Provider is a hospital, the Contractor shall identify the number of doctors that would not have admitting privileges in the absence of such Participating hospital.
 - d) If the Participating Provider is a hospital and the Contractor and the hospital are in agreement that the termination or non-renewal will occur on the scheduled date indicated, separate written notice must be submitted to the Department from the hospital and the Contractor. Both letters must be submitted as part of the forty-five (45) day notification to the Department. The Contractor must also provide the hospital with a copy of the "MCO/Hospital Terminations and Non-Renewal Guidelines" making the hospital aware of its responsibilities during the cooling off period, including, but not limited to, submission of a sample member notice, if applicable, to the Department for review and approval. In addition, the Contractor must submit the impact/disruption analysis.
 - e) If the Participating Provider is a hospital and either party desires to continue negotiations, all notices or requests submitted to the Department by the Contractor or hospital must include a copy to the other contracted party to the agreement. If the Contractor and the hospital do not submit a letter indicating the termination will occur as scheduled, the Department will assume the parties will continue to negotiate and Enrollees will be afforded the two months cooling off period as defined in statute. The Contractor must pay and the hospital must accept the previous contracted rate during the two month cooling off period. The Contractor must submit an impact/disruption analysis and draft notices to the Department for review upon the termination unless a contract extension is secured. If the Contractor and the hospital extend the term of the agreement, the extended date becomes the new termination date for purposes of PHL § 4406-c (5-c).

- f) If the Participating Provider is a hospital and either party wishes to request a waiver of the cooling off period, a written request must be made to the Director of the Division of Long Term Care no more than five business days after the Contractor submits the notice of termination to the Department. The waiver request must include a detailed rationale as to why the cooling off period should not be afforded to Enrollees. The Department will respond to the request within three business days. If the Department denies the waiver request, the Contractor and the hospital must adhere to the specifications above. If the Department issues a waiver of the cooling off period, the Contractor must immediately submit draft Enrollee notices and an impact/disruption analysis to the Department in order to issue timely notification.
- g) In addition to the notification required in (a) above, the Contractor shall develop a transition plan for Enrollees who are patients of the Participating Provider withdrawing from the Contractor's network subject to approval by the Department. The Department may direct the Contractor to provide notice to the Enrollees who are patients of PCPs or specialists including available options for the patients, and availability of continuing care, not less than thirty (30) days prior to the termination or expiration of the Provider Agreement. To the extent practicable, such notices shall be forwarded to the Department for review and approval forty-five (45) days prior to the termination or expiration of the Provider Agreement. In the event that Provider Agreements, other than those with hospitals, are terminated or are not renewed with less than the notice period required by this Section, the Contractor shall immediately notify the Department, and develop a transition plan on an expedited basis and provide notice to affected Enrollees upon the Department's consent to the transition plan and Enrollee notice.
- h) If the Participating Provider is a hospital and the Contractor and the hospital agree to the termination or non-renewal so there will be no cooling off period, notices must be issued to Enrollees at least thirty (30) days prior to the termination and must reflect all transitional care requirements pursuant to PHL § 4406-c (5-c) and § 4403.6 (e). If notices are not sent thirty (30) days prior to the scheduled termination or non-renewal, the termination date must be adjusted to allow the required thirty (30) day notification to Enrollees.
- i) If the Contractor and the hospital continue negotiations and a cooling off period begins, notices must be issued to Enrollees within fifteen (15) days of the commencement of the cooling off period and must include language regarding the cooling off period and transitional care. When a cooling off period is required, notice may not be issued to Enrollees by either party prior to the start of the cooling off period.
- j) If the Department issues a waiver of the cooling off period, the Contractor must immediately submit draft Enrollee notices and an impact/disruption analysis to the Department in order to issue timely notification. The notices must be sent to Enrollees at least thirty (30) days prior to the scheduled termination unless a contract extension is secured. If Enrollee notices are not sent at least thirty (30) days prior to the scheduled termination or non-renewal, the termination date must be adjusted to allow the required thirty (30) day notification to Enrollees.

- k) Upon Contractor notice of failure to renew, or termination of, a Provider Agreement, the Department, in its sole discretion, may waive the requirement of submission of a contingency plan upon a determination by the Department that:
 - i) the impact upon Enrollees is not significant, and/or
 - ii) the Contractor and Participating Provider are continuing to negotiate in good faith and consent to extend the Provider Agreement for a period of time necessary to provide not less than thirty (30) days notice to Enrollees.
- l) The Department reserves the right to take any other action permitted by this Agreement and under regulatory or statutory authority, including but not limited to terminating this Agreement.

I. Recovery of Overpayments to Providers

- 1. a) Consistent with the exception language in Section 3224-b of the Insurance Law, the Contractor shall have and retain the right to audit Participating Providers' claims for a ten (10) year period from the date the care, services or supplies were provided or billed, whichever is later, and to recoup any overpayments discovered as a result of the audit. This ten (10) year limitation does not apply to situations in which fraud may be involved or in which the provider or an agent of the provider prevents or obstructs the Contractor's auditing.
 - b) The parties acknowledge that the New York State Office of the Attorney General, the Department, the Office of the Medicaid Inspector General (OMIG) and the Office of the State Comptroller (OSC) have the right to recover overpayments, penalties, and other damages from Participating Providers, Non-Participating Providers, Contractors, subcontractors, and third parties in the Contractor's network as a result of any investigation, audit or action commenced by the New York State Office of the Attorney General, the Department, OMIG, and OSC, including, but not limited to any litigation brought pursuant to State Finance Law § 187 et seq. or 31 U.S.C. § 3729 et seq. The Contractor shall not have a right to recover from the State any recovery obtained by the State pursuant to 31 U.S.C. § 3729 et seq., State Finance Law § 187 et seq., or other New York or Federal statutes, regulations or rules.
 - c) The parties agree that where the Contractor has previously recovered overpayments, by whatever mechanism utilized by the Contractor, from a Participating Provider, said overpayment recovery shall not be recovered from that Participating Provider for any such previously recovered identifiable claims that are the subject of a further investigation, audit or action commenced by the agencies listed in Section I(1)(b).
 - d) The parties agree that where the Contractor has recovered overpayments from a Participating Provider, the Contractor shall retain said recoveries.
- 2) Nothing in this Agreement shall be construed to limit the authority of the New York State Office of the Attorney General, OMIG, OSC or the Department to investigate, audit or otherwise obtain recoveries from any Participating Provider, Non-Participating Provider, Contractor, subcontractor, or third party.

J. Optometry Services Provided by Article 28 Clinics Affiliated with the College of Optometry of the State University of New York.

- a. Consistent with Chapter 37 of the Laws of 2010 amending Section 364-j of the Social Services Law, optometry services provided by Article 28 clinics affiliated with the College of Optometry of the State University of New York may be accessed directly by Enrollees without the Contractor's prior approval and without regard to network participation.
- b. The Contractor will reimburse non-participating Article 28 clinics affiliated with the College of Optometry of the State University of New York for covered optometry services provided to Enrollees at Article 28 Medicaid fee-for-service clinic rates.

K. Dental Services Provided by Article 28 Clinics Operated by Academic Dental Centers not Participating in Contractor's Network.

- a. Consistent with Chapter 697 of the Laws of 2003 amending Section 364-j of the Social Services Law, dental services provided by Article 28 clinics operated by academic dental centers may be accessed directly by Enrollees without prior approval and without regard to network participation.
- b. The Contractor will reimburse non-participating Article 28 clinics operated by academic dental centers for covered dental services provided to Enrollees at approved Article 28 Medicaid clinic rates in accordance with the protocols issued by the Department.

L. Home Care Services Worker Wage Parity Rules

The Contractor is required to comply with the home care worker wage parity law at Section 3614-c of the Public Health Law and all applicable notices and regulations issued pursuant to subdivisions 8 and 9 therein. These requirements apply to New York City, Nassau, Suffolk, and Westchester Counties.

The Contractor shall certify to the Department annually, on forms provided by the Department, that all home care aide services, whether provided by the Contractor or through a subcontractor, are in compliance with PHL § 3614-c.

The Contractor shall require subcontractors employing home care aides to certify to the Contractor annually, on forms provided by the Department, that all home care aide services provided through the subcontractor are in compliance with PHL § 3614-c.

The Contractor shall quarterly collect, and require subcontractors to provide, sufficient information to verify that subcontractors employing home care aides are in compliance with PHL § 3614-c. The Contractor shall develop protocols to establish a verification system to demonstrate compliance with requirements. Such verification system must be sufficient to verify that home care aide wages provided by each subcontractor meet or exceed the local wage requirements pursuant to subdivision 3 and applicable notices and regulations. Solely collecting the certification or an attestation of compliance is not sufficient to meet this requirement. The local wage requirements are subject to change pursuant to subdivision 3 and applicable notices and regulations, all wages provided must comply with the current rate in effect.

Failure to fully comply with the home care worker wage parity requirements may result in non-payment of services rendered, as required by PHL § 3614-c (2).

M. Fair Labor Standards Act

The Contractor is required to comply with all applicable provisions of the Fair Labor Standards Act (FLSA). The Contractor shall develop protocols to establish a verification system to demonstrate compliance with requirements. Such protocols shall include appropriate record keeping methodologies, tracking of aide travel time, hours worked on live-in cases, and appropriate rate reimbursement. Such verification system and protocols are subject to audit by DOH, OMIG, and the Department of Labor.

ARTICLE VI

RECORDS AND REPORTING REQUIREMENTS

A. Maintenance of Contractor Performance Records, Records Evidencing Enrollment Fraud and Documentation Concerning Duplicate CINs

1. The Contractor shall maintain a health information system that collects, analyzes, integrates and reports data that meets the requirements of 42 CFR 460 Subpart L and Article 44 of the Public Health Law.

The Contractor agrees to maintain for each Enrollee a comprehensive medical record. The Contractor shall maintain, and shall require its Providers to maintain:

- (a) Appropriate records related to services provided to Enrollees;
 - (b) all financial records and statistical data that the LDSS, the Department and any other authorized governmental agency may require including books, accounts, journals, ledgers, and all financial records relating to capitation payments, third party health insurance recovery, and other revenue received, any reserves related thereto and expenses incurred under this Contract;
 - (c) appropriate financial records to document fiscal activities and expenditures, including records relating to the sources and application of funds and to the capacity of the Contractor or its providers, including its participating providers, if relevant, to bear the risk of potential financial losses;
 - (d) all documents concerning enrollment fraud or the fraudulent use of any CIN; and
 - (e) all documents concerning duplicate CINs.
2. Credentials for providers shall be maintained on file by or in a manner accessible to the Contractor and furnished to the Department, upon request.

B. Maintenance of Financial Records and Statistical Data

The Contractor shall maintain all financial records and statistical data according to generally accepted accounting principles and/or statutory accounting principles where applicable.

C. Access to Contractor Records

The Contractor shall provide the LDSS, SDOH, the Comptroller of the State of New York, the Attorney General of the State of New York, DHHS, the Comptroller General of the United States, and their authorized representatives with access to all records relating to Contractor performance under this Contract for the purposes of examination, audit, and copying (at reasonable cost to the requesting party) of such records. The Contractor shall give access to such records on two (2) business days prior written notice, during normal business hours, unless otherwise provided or permitted by applicable laws, rules, or regulations. Notwithstanding the foregoing, when records are sought in connection with a “fraud” or “abuse” investigation, as defined respectively in 10 NYCRR §98.1.21 (a)(1) and (a)(2), all costs associated with the production and reproduction shall be the responsibility of the Contractor.

D. Retention Periods

The Contractor shall preserve and retain all records relating to Contractor performance under this Contract in readily accessible form during the term of this Contract and for a period of ten (10) years thereafter. All provisions of this Contract relating to record maintenance and audit access shall survive the termination of this Contract and shall bind the Contractor until the expiration of a period of ten (10) years commencing with termination of this Contract or if an audit is commenced, until the completion of the audit, whichever occurs later.

E. Reporting Requirements

1. The Contractor shall be responsible for fulfilling the reporting requirements of this Contract. Reports shall be filed in a format specified by the Department and according to the time schedules required by the Department.
2. The Contractor shall furnish all information necessary for the Department to assure adequate capacity and access for the enrolled population and to demonstrate administrative and management arrangements satisfactory to the Department. The Contractor shall submit periodic reports to the Department in a data format and according to a time schedule required by the Department to fulfill the Department’s administrative responsibilities under Section 4403-f of Article 44 of Public Health law and other applicable State and federal laws or regulations. Reports may include but are not limited to information on: availability, accessibility and acceptability of services; enrollment; Enrollee demographics; disenrollment; Enrollee health and functional status (including the Semi-Annual Assessment of Members {SAAM} or any other such instrument the Department may request); service utilization; encounter data, Enrollee satisfaction; marketing; grievance and appeals; and fiscal data. The Contractor shall promptly notify the Department of any request by a governmental entity or an organization working on behalf of a governmental entity for access to any records maintained by the Contractor or a subcontractor pursuant to this Contract.
3. The Contractor shall submit the following specific reports to the Department.

(a) Annual Financial Statements

In accordance with Part 98-1.16, the Contractor shall file in duplicate with both the Commissioner and the Superintendent of the Department of Financial Services (DFS) a financial statement each year in the form prescribed by the Commissioner known as the Medicaid Managed Care Operating Report (MMCOR). The MMCOR shows the condition at last year-end and contains the information required by section 4408 of the Public Health Law.

The due date for annual statements shall be April 1 following the report closing date.

(b) Quarterly Financial Statements

The Contractor shall submit quarterly financial statements to the Department and DFS. The due date for quarterly reports shall be forty-five (45) days after the end of the calendar quarter.

(c) Other Financial Reports

Contractor shall submit financial reports, including certified annual financial statements, and make available documents relevant to its financial condition to the Department and DFS in a timely manner as required by State laws and regulations including but not limited to PHL § 4403-f, 4404 and 4409, Title 10 NYCRR § 98-1.11, 98-1.16, and 98-1.17 and any applicable Insurance Law 304, 305, 306, and 310.

(d) Encounter Data

The Contractor shall prepare and submit encounter data on a bimonthly (twice a month) basis, as specified by the Department, to the Department through its designated Fiscal Agent. Unless otherwise directed by the Department, encounter data shall not be submitted to the Department, or its designated Fiscal Agent, more than 15 days from the date of adjudication of the corresponding claim. Each provider is required to have a unique identifier. Submissions shall be comprised of encounter records or adjustments to previously submitted records which the Contractor has received and processed from provider encounter or claim records of any contracted or directly provided services rendered to the Enrollee in the current or any preceding months.

Twice a month submissions must be received by the Department, or its designated Fiscal Agent, consistent with the timeframes specified above, to assure the submission is included in the Department's or its designated Fiscal Agent's twice a month production processing.

The Contractor shall submit an annual notarized attestation that the encounter data submitted through the designated Fiscal Agent is, to the best of the Contractor's information, knowledge and belief, accurate and complete. The encounter data submission must comply with the format prescribed by the Department or its designated Fiscal Agent and shall include the name and provider number of any ordering, referring, prescribing, or attending provider and information on the rendering/operating/other professional. Generic Provider IDs shall be used only when specific Provider IDs remain unknown after reasonable inquiry. NPI numbers of providers not enrolled in Medicaid must be reported. If the NPI is not available, the Contractor shall report the Tax Payer ID of the provider or professional.

The Contractor may report encounter data records that have not been adjudicated from the provider submitted claim/encounter in the regular claims system, such as data collected through medical record review, if the following conditions are met:

The Contractor shall ensure that medical records, notes and documentation constituting the source of the submitted data be available for review by the Department for a period of ten (10) years from the date of service.

Proof is maintained by the Contractor that an Explanation of Benefits (EOB) was sent to the

provider for all Medicaid Encounter Data collected and submitted to MEDS III, or its successor system, with the diagnosis and procedures clearly specified.

The internal data system storing these records is subject to audit.

All records created or modified through this information gathering process must be made identifiable to the Department using unique encounter control numbers (ECNs). Algorithms used to assign ECNs for these records must be sent to the Department prior to data submission.

Contractor shall ensure to the best of the Contractor's knowledge, information, and belief, that all required encounter data fields are submitted to the Fiscal Agent and are populated with accurate and complete data.

The Contractor shall maintain information as to the ordering/referring, prescribing or attending provider and information on the rendering/operating/other professional relating to an encounter and the Contractor shall report such ordering/referring, prescribing or attending provider and information on the rendering/operating/other professional information via data provided to the Fiscal Agent in accordance with this Section.

Consistent with the procedures established and in a format to be developed by the Department, the Contractor shall report the NYS provider license number and NPI of any subcontractor performing services. Where the subcontractor performing services does not have a NYS provider license number or NPI, the Contractor shall report the Tax Payer ID of the subcontractor.

The Contractor acknowledges that the Department may, in its discretion, assess penalties for untimely, incomplete or inaccurate submission of encounter data pursuant to SSL 364-j (32).

(e) Fraud and Abuse Reporting Requirements

A) The Contractor must submit to the Department and Office of the Medicaid Inspector General (OMIG) the following information on an ongoing basis for each reasonably suspected or confirmed case of fraud and abuse it identifies through Complaints, organizational monitoring, contractors, providers, beneficiaries, Enrollees, or any other source:

1. The name of the individual or entity that committed or is reasonably suspected of committing the fraud or abuse;
2. The source that identified the reasonably suspected or confirmed fraud or abuse;
3. The type of provider, entity or organization that committed or is reasonably suspected of committing the fraud or abuse;
4. A description of the reasonably suspected or confirmed fraud or abuse;
5. The approximate dollar amount of the reasonably suspected or confirmed fraud or abuse;
6. The legal and administrative disposition of the case, if available, including actions taken by law enforcement officials to whom the case has been referred;
7. No disposition of any case by the Contractor shall limit the authority of the New York State Office of the Attorney General, Department, OMIG, or the Office of State Comptroller (OSC) to investigate, audit, or obtain recoveries from any Participating Provider, Non-Participating Provider, Contractor, subcontractor, or third party, and

8. Other data/information as prescribed by the Department and OMIG.
- B) Such report shall be submitted when cases of fraud and abuse are reasonably suspected or confirmed, and shall be reviewed and signed by an executive officer of the Contractor.
1. Unless prior written approval is obtained from SDOH or OMIG, after reporting a case of reasonably suspected or confirmed fraud or abuse, the Contractor shall not take any of the following actions:
 - a. Inform the subject of the report of the existence of the referral or investigation.
 - b. Enter into or attempt to negotiate any settlement or agreement regarding the case of fraud or abuse; or
 - c. Impose or accept any credit, debit, or offset in connection with the case of fraud or abuse.
 - iii. The Contractor will report to the Department and OMIG any reasonably suspected or confirmed criminal activity or fraud or abuse committed by an Enrollee, provider, rendering professional, the Contractor, a subcontractor, or Contractor's employees or management, or third party where there is a suspicion of such activity, within seven (7) days of learning of such behavior. Such report will be in a manner proscribed by the Department, in consultation with OMIG. For the purposes of this Section, reasonably suspected criminal activity and/or fraud and abuse includes but is not limited to, submitting claims for services not rendered, providing unnecessary services, or possessing forged documents including prescriptions.
 - iv. The Contractor shall report monthly to the Department and OMIG, in a form and format to be determined by the Department and OMIG, any Participating Providers who the Contractor has terminated "for cause." "For cause" includes, but is not limited to, fraud and abuse; integrity; or quality.
 - v. The Contractor shall report monthly to the Department and OMIG, in a form and format to be determined by the Department and OMIG, any Participating Providers who the Contractor has not renewed its Participating Provider agreement with "for cause." "For cause" includes, but is not limited to, fraud and abuse; integrity; or quality.
- (f) Grievance and Appeal Reports
- i) The Contractor must provide the Department on a quarterly basis, and within fifteen (15) business days of the close of the quarter, a summary of all grievance and appeals received during the preceding quarter using a data transmission method that is determined by the Department.
 - ii) The Contractor also agrees to provide on a quarterly basis, within fifteen (15) business days of the close of the quarter, the total number of grievance or appeals that have been unresolved for more than thirty (30) days. The Contractor shall maintain records on these and other grievances or appeals, which shall include all correspondence related to the grievance or appeal, and an explanation of disposition. These records shall be readily available for review by the Department or entity designated by the State upon request.

- iii) Nothing in this Section is intended to limit the right of the Department and the entity designated by the State to obtain information immediately from a Contractor pursuant to investigating a particular Enrollee grievance or appeal, or provider complaint.

(g) Performance Improvement Projects

The Contractor will be required to conduct at least one (1) performance improvement project each year, in a priority topic selected by the plan and approved by the Department. The purpose of these studies will be to promote quality improvement within the managed long-term care demonstration. Results of these annual studies will be provided to the Department in a required format. Results of other performance improvement projects will be included in the minutes of the quality committee and reported to the Department upon request.

(h) Enrollee Health and Functional Status

The Contractor shall submit Enrollee health and functional status data for each of their Enrollees in the format and according to the timeframes specified by the Department. The data shall consist of the Semi-Annual Assessment of Members (SAAM) or any other such instrument the Department may request. The data shall be submitted at least semi-annually or on a more frequent basis if requested by the Department.

(i) Additional Reports

Upon request by the Department, the Contractor shall prepare and submit other operational data reports. Such requests will be limited to situations in which the desired data is considered essential and cannot be obtained through existing Contractor reports. Whenever possible, the Contractor will be provided with ninety (90) days notice and the opportunity to discuss and comment on the proposed requirements before work is begun. However, the Department reserves the right to give thirty (30) days notice in circumstances where time is of the essence.

(j) Ownership and Related Information Disclosure

The Contractor shall report ownership and related information to SDOH, and upon request to the Secretary of Health and Human Services and the Inspector General of Health and Human Services, in accordance with 42 U.S.C. §§ 1320a-3 and 1396b(m)(4) (Sections 1124 and 1903(m)(4) of the SSA).

Pursuant to 42 CFR 455.104, the Contractor will obtain a disclosure of complete ownership, control, and relationship information from all MCO Providers.

Pursuant to 42 CFR 455.105, within 35 days of the date of a request by SDOH, OMIG or DHHS, the Contractor will require from any subcontractor disclosure of ownership, with whom an individual network Provider has had a business transaction totaling more than \$25,000 during the 12 month period ending on the date of request.

(k) Professional Discipline

Pursuant to PHL § 4405-b, the Contractor shall; have in place policies and procedures to report to the appropriate professional disciplinary agency within thirty (30) days of occurrence of any of the

following:

- i. the termination of a health care Provider Agreement pursuant to Section 4406-d of the PHL for reasons relating to alleged mental and physical impairment, misconduct or impairment of patient safety or welfare;
- ii. the voluntary or involuntary termination of a contract or employment or other affiliation with such Contractor to avoid the imposition of disciplinary measures;
- iii. the termination of a health care Participating Provider Agreement in the case of a determination of fraud or in a case if imminent harm to patient health.

The Contractor shall make a report to the appropriate professional disciplinary agency within thirty (30) days of obtaining knowledge of any information that reasonably appears to show that a health professional is guilty of professional misconduct as defined in Articles 130 and 131-A of the New York State Education Law (Education Law)

Pursuant to CFR 1002.3(b), the Contractor will report to the Department and OMIG any adverse actions taken for program integrity reasons against Providers. The Contractor will notify the Department of any Provider denied credentialing or termination of the Provider's contract for program integrity related reasons such as being on the excluded Provider list and/or having existing fraud, licensing or Office of Professional Medical Conduct (OPMC) issues.

(l) Certification Regarding Individuals Who Have Been Debarred or Suspended By Federal or State Government

- i. Contractor will certify to the SDOH initially and immediately upon changed circumstances from the last such certification that it does not knowingly have an individual who has been debarred or suspended by the federal, state or local government, or otherwise excluded from participating in procurement activities:
 - A. as a director, officer, partner or person with beneficial ownership of more than five percent (5%) of the Contractor's equity; or
 - B. as a party to an employment, consulting or other agreement with the Contractor for the provision of items and services that are significant and material to the Contractor's obligations in the Medicaid managed care program, consistent with requirements of SSA § 1932 (d)(1).
- ii. Pursuant to 42 CFR 455.101, the Contractor is required to check against the Medicaid excluded Provider list any employee in the capacity of general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day to day operations at initial hiring and periodically thereafter.
- iii. The Contractor is required to check new Providers, re-enrolled Providers and all current Participating Providers against the Excluded Provider List on a monthly basis, which includes updates from the List of Excluded Individuals and Entities (LEIE) and the Restricted, Terminated or Excluded Individuals or Entities List. The Contractor will require all network Providers to monitor staff and

employees against the stated exclusion list and report any exclusions to the Contractor on a monthly basis.

(m) Conflict of Interest and Business Transaction Disclosures

- i. Conflict of Interest Disclosure: Contractor shall report to SDOH, in a format specified by SDOH, documentation, including but not limited to the identity of and financial statements of, person(s) or corporation(s) with an ownership or contract interest in the managed care plan, or with any subcontract(s) in which the managed care plan has a five percent (5%) or more ownership interest, consistent with requirements of SSA § 1903 (m)(2)(a)(viii) and 42 CFR 455.100 through 455.104.
- ii. Business Transaction Disclosure: Pursuant to 42 CFR 455.105(b)(2), the Contractor will furnish to the State and the U.S. Department of Health and Human Services (HHS) information about certain business transactions with wholly owned suppliers or any subcontractors. The Contractor will submit requested information within 35 days of the date of a request by HHS or the SDOH.

(n) Disclosure of Criminal Activity

Pursuant to 42 CFR 455.106, the Contractor will disclose to SDOH any criminal convictions by managing employees related to Medicare, Medicaid, or Title XX programs at the time the Contractor applies or renews an application for participation in the Medicaid managed care program or Family Health Plus program or at any time on request. SDOH is required to notify the HHS-Office of Inspector General (HHS-OIG) whenever such disclosures are made.

Pursuant to 42 CFR 455.106, the Contractor will require Providers to disclose health care related criminal conviction information from all parties affiliated with the Provider. Upon entering into an initial agreement or renewal of any agreement between the Contractor and its Providers, the Contractor must disclose to SDOH any conviction of a criminal offense related to that Provider or Provider's managing employee involvement in any program under Medicare, Medicaid, or Title XX services program.

(o) Provider Investigative Report

The Contractor shall submit to the Department and OMIG a quarterly report, in a form and format to be determined by OMIG in consultation with the Department, of all Participating Provider and Non-Participating Provider investigative and educational or re-educational activities. This report will include, but is not limited to, copies of any agreements executed between the Contractor and Participating Providers and Non-Participating Providers as a result of the action and a summary of the investigative results.

F. Data Certification

The Contractor shall comply with the Department's data certification requirements.

1. The types of data subject to certification include, but are not limited to, enrollment information, encounter data, the premium proposal, contracts and all other financial data. The certification shall be in a format prescribed by the Department and must be sent at the time the report or

data are submitted.

2. The certification shall be signed by the plan's Chief Executive Officer and/or the Chief Financial Officer; and, the certification shall attest to the accuracy, completeness and truthfulness of the data.

G. Notification of Changes in Report Due Dates Requirements or Formats

The Department may extend due dates, or modify report requirements or formats upon a written request by the Contractor to the Department, where the contractor has demonstrated a good and compelling reason for the extension or modification. The Department will issue a written response to the request for a modification or extension of due date.

H. Ownership and Related Information Disclosure

The Contractor shall report ownership and related information to the Department, and upon request to the Secretary of Department of Health and Human Services and the Inspector General of Health and Human Services, in accordance with 42 U.S.C. (Section 1320a-3 and 1396b(m) (4) Sections 1124 and 1903(m)(4) of the Federal Social Security Act).

I. Public Access to Reports

Any data, information, or reports collected and prepared by the Contractor and submitted to New York State authorities in the course of performing their duties and obligations under this Contract will be deemed to be records of the Department and may be disclosed subject to and consistent with the requirements of Freedom of Information Law.

J. Professional Discipline

1. Pursuant to P.H.L. Section 4405-b, the Contractor shall have in place policies and procedures to report to the appropriate professional disciplinary agency within thirty (30) days of occurrence, any of the following:
 - (a) the termination of a health care provider contract pursuant to Section 4406-d of the Public Health Law for reasons relating to alleged mental and physical impairment, misconduct or impairment of patient safety or welfare;
 - (b) the voluntary or involuntary termination of a contract or employment or other affiliation with such contractor to avoid the imposition of disciplinary measures; or
 - (c) the termination of a health care provider contract in the case of a determination of fraud or in a case of imminent harm to patient health.
2. The Contractor shall make a report to the appropriate professional disciplinary agency within thirty (30) days of obtaining knowledge of any information that reasonably appears to show that a health professional is guilty of professional misconduct as defined in Articles 130 and 131 (a) of the State Education Law.

K. Certification Regarding Individuals Who Have Been Debarred or Suspended By Federal

or State Government.

Contractor will certify to the Department initially and immediately upon changed circumstances from the last such certification that it does not knowingly have an individual who has been debarred or suspended by the federal or state government, or otherwise excluded from participating in procurement activities:

1. as a director, officer, partner or person with beneficial ownership of more than 5% of the Contractor's equity; or
2. as a party to an employment, consulting or other agreement with the Contractor for the provision of items and services that are significant and material to the Contractor's obligations in the managed long term care plan, consistent with requirements of SSA §1932 (d)(1).

L. Conflict of Interest Disclosure

The Contractor shall report to the Department in a format specified by the Department documentation, including but not limited to the identity of and financial statements of person(s) or corporation(s) with an ownership or contract interest in the managed long-term care plan, or with any Subcontract(s) in which the managed long-term care plan has a 5% or more ownership and interest, consistent with requirements of SSA § 1903 (m)(2)(a)(viii) and 42 CFR§ §455.100 and 455.104.

M. OMIG's Right to Audit and Recover Overpayments Caused by Contractor Submission of Misstated Reports

The Office of the Medicaid Inspector General (OMIG) can perform audits of financial reports filed by Contractors after SDOH reviews and accepts the Contractor's report. If the audit determines that the Contractor's filed report contained misstatements of fact, causing the Contractor and/or other Contractors to receive an inappropriate capitation rate, the OMIG will recover any and all overpayments. The Contractor will be entitled to the audit rights afforded to providers in Section 517.5 and Section 517.6 of Title 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York. Nothing in this section shall limit SDOH, OMIG, or any other auditing entity from the development of alternative audit and/or recovery rights for time periods prior to the contract period, during the contract period, or subsequent to the contract period, or limit other remedies or rights available to SDOH, OMIG, or any other auditing entity relating to the timeliness, completeness and/or accuracy of the Contractor's reporting submission.

N. OMIG's Right to Audit and Recover Overpayments Which Were Caused by the Contractor's Misstated Encounter Data

The Office of the Medicaid Inspector General (OMIG) can perform audits of the Contractor's submitted encounter data after DOH has reviewed and accepted the Contractor's encounter data submission. If the audit determines the Contractor's encounter data was incorrectly submitted and the Contractor received additional or higher Medicaid managed care capitation rate payments due to the incorrect encounter data, OMIG can recover from the Contractor the additional Medicaid funds that the Contractor received because of the encounter data misstatement. The Contractor will be entitled to the audit rights afforded to providers in Section 517.5 and Section 517.6 of Title 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York. Nothing in this section shall limit SDOH, OMIG or any other auditing entity from the development of

alternative audit and/or recovery rights for time periods prior to the contract period, during the contract period, or subsequent to the contract period or limit other remedies or rights available to SDOH, OMIG or any other auditing entity relating to the timeliness, completeness and/or accuracy of the Contractor's reporting submission.

O. OMIG Compliance Review Authority

In accordance with New York State Public Health Law sections 30 – 36, and as authorized by federal or state laws and regulations, OMIG may conduct reviews of Participating Providers' compliance programs, as well as Contractors' compliance with the requirements of 42 U.S.C. § 1396a(a)(68) and 18 NYCRR Part 521.

P. Notification to Audit

1. The Contractor shall notify the OMIG of its intention to initiate an audit of a Participating Provider or Non-Participating Provider. The following shall constitute the notification process. For the purposes of this Section, an audit refers to activity which will or may result in a post payment recovery and/or referral to the OMIG in accordance with Article IX, Section BB of this Contract.
 - a. The notification to audit shall be communicated by the Contractor to the OMIG in a form and format to be determined by SDOH and OMIG. The notification to audit shall include (at a minimum) the following information: provider name, provider address, audit scope and time period to be reviewed.
 - b. Upon receipt of the Contractor's notification to audit, the OMIG shall within ten (10) business days:
 - i. Acknowledge receipt of the notification; and
 - ii. Acknowledge that there is no conflict with the Contractor conducting the audit; or
 - iii. Alert the Contractor to stop the audit or any further activity if a conflict exists.
 - c. If the Contractor does not receive a response from the OMIG in ten (10) business days, the Contractor may proceed with its audit.
 - d. Notwithstanding the above, the OMIG may initiate an audit of the Contractor's provider at any time
2. The OMIG shall notify the Contractor of its intention to initiate an audit of a Participating Provider in the Contractor's network or Non-Participating Provider. The following shall constitute the notification process.
 - a. The OMIG shall email the notification to audit to the Contractor's designee. The notification to audit shall include (at a minimum) the following information: provider name, provider address, audit scope and time period to be reviewed.
 - b. Upon receipt of OMIG's notification to initiate an audit, the Contractor's designee shall respond within ten (10) business days as follows:
 - i. Acknowledge receipt of the notification by email; and/or
 - ii. Alert the OMIG of a conflict.
 - c. If the OMIG does not receive a response from the Contractor within ten (10) business days, the OMIG may proceed with its audit.

- d. Upon receipt of OMIG's notification to initiate an audit, the Contractor shall provide to OMIG, in a form and format required by OMIG, all records required by OMIG to complete its audit, investigation or review of the Contractor's Participating or Non-Participating Provider, or subcontractor. The Contractor shall provide such records to the OMIG within ten (10) business days of OMIG's notification to initiate an audit.
3. Once notified of OMIG's intent to audit a Participating Provider or Non-Participating Provider, the Contractor shall not take any of the following actions as they specifically relate to Medicaid claims, and the audit scope and time period identified in OMIG's notification of intent to audit:
 - a. Initiate an audit of the same provider;
 - b. Enter into or attempt to negotiate any settlement agreement with the provider; or
 - c. Accept any monetary or other thing of valuable consideration offered by the provider.

ARTICLE VII

RENEWAL OR TERMINATION OF THE CONTRACT

A. Renewal

1. The Department, with the approval of the State Comptroller or his designee, may extend the term of the Contract for up to two (2) additional one (1) year terms. Standard Appendix X is the form to be used in extension of this Contract. The Department will provide written notice to the Contractor of extension of the term of the Contract at least 90 days prior to the end of the term.
2. If the Department intends to let the Contract expire, the Department will notify the Contractor in writing at least 90 days in advance of the termination of the Contract. This notice shall have the same effect on the Contractor as a notice of termination, including but not limited to provisions of this Contract with respect to Phase Out and Transition.

B. Termination of the Contract by the Department

1. The Department shall have the right to terminate this Contract at any time, if the Contractor, in the Department's determination:
 - (a) Takes any action that threatens the health, safety, or welfare of any Enrollee;
 - (b) Has engaged in an unacceptable practice under 18 NYCRR PART 515;
 - (c) Has failed to substantially comply with applicable standards of the Public Health Law and regulations or has had its certificate of authority suspended, limited, or revoked;
 - (d) Materially breaches the Contract, including the PACE Program Agreement, and such breach or failure is not cured within thirty (30) days of the date of the Department's notice of breach or noncompliance, or such longer period as the Department may allow;

- (e) Becomes unable to meet its obligations in the normal course of business including but not limited to circumstances beyond control and changes to the provider network affecting Enrollee access; or
 - (f) Brings a proceeding voluntarily, or has a proceeding brought against it involuntarily, under Title 11 of the U.S. Code (the Bankruptcy Code) and the petition is not vacated within thirty (30) days of its filing.
2. This Contract shall terminate immediately: if the Contractor's authority to operate a PACE expires under Section 4403-f of Public Health Law; Section 1934 of the Social Security Act; any other applicable state or federal law; or upon termination or non-renewal of the PACE Program Agreement.
 3. This Contract shall terminate immediately if federal financial participation in the costs hereof become unavailable or if State funds sufficient to fulfill the obligation of the Department hereunder are not appropriated by the State Legislature.
 4. Notice of termination by the Department. The Department shall give the Contractor prompt written notice of termination of this Contract, specifying the applicable termination provision(s) and the effective date of termination.

C. Termination of the Contract by the Contractor

1. The Contractor shall have the right to terminate this Contract, if the Department:
 - (a) Fails to make agreed-upon payments in a timely and accurate manner;
 - (b) Materially breaches the Contract or fails to comply with any material term or condition of this Contract.
2. The Contractor shall allow thirty (30) days, or such longer period as the Contractor may permit, from the time of the Contractor's written request for performance, for the Department to cure the identified deficiency.
3. The effective date of such termination shall be at least 90 days from the date of the notice of the alleged breach and intent to terminate for cause.
4. Notice by the Contractor. The Contractor shall give the Department written notice of termination of this Contract, specifying the provision(s) breached and the effective date of termination.

D. Effect of Termination on New Enrollments

Once either Party has given notice of its intentions to terminate this Contract, the Contractor shall suspend enrollment into its PACE plan.

E. Phase out; Transition

1. This Contract shall be terminated in accordance with the approved termination phase-down

plan in the PACE Program Agreement.

2. The Contractor agrees to provide all information and assistance to the Department that the Department deems necessary to complete an orderly transition. This includes but is not limited to: transfer of financial and medical records, completion of final reports and audits and cooperation with the LDSS in the transfer of Enrollees to alternative care.
3. This provision shall survive the termination of this Contract.

ARTICLE VIII

INTERMEDIATE SANCTIONS AND REQUIREMENTS OF OTHER LAWS AND REGULATIONS

- A. The Contractor is subject to the imposition of sanctions as authorized by State law and regulation including the Department's right to impose sanctions for unacceptable practices as set forth in Title 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York (NYCRR) Part 515 and civil and monetary penalties pursuant to 18 NYCRR Part 516 and 42 CFR 460 and such other sanctions and penalties as are authorized by local laws and ordinances and resultant administrative codes, rules and regulations related to the Medical Assistance Program or to the delivery of the contracted for services.
- B. Unacceptable practices for which the Contractor may be sanctioned include but are not limited to:
 1. Failing to provide medically necessary services that the Contractor is required to provide under its contract with the State.
 2. Imposing premiums or charges on Enrollees.
 3. Discriminating among Enrollees on the basis of their health status or need for health care services.
 4. Misrepresenting or falsifying information that it furnishes to an Enrollee, Applicant, potential Enrollee, health care provider, the State or to CMS.
 5. Distributing directly or through any agent or independent contractor, marketing materials that have not been approved by the State and CMS or that contain false or materially misleading information.
 6. Violating any other applicable requirements of SSA 1903(m) or 1932 and any implementing regulations.
 7. Violating any other applicable requirements of 18 NYCRR or 10 NYCRR Part 98.
 8. Failing to comply with the terms of this Agreement.
- C. Intermediate Sanctions may include but are not limited to:

1. Civil monetary penalties
 2. Suspension of all new enrollment, after effective date of the sanction.
 3. Termination of the contract, pursuant to Article VII of the Agreement.
- D. The Department shall have the right, upon notice to the LDSS, to limit, suspend or terminate enrollment activities by the Contractor and/or enrollment into the PACE Program upon ten (10) days written notice to the Contractor. The written notice shall specify the action(s) contemplated and the reason(s) for such action(s) and shall provide the Contractor with an opportunity to submit additional information that would support the conclusion that limitation, suspension or termination of enrollment activities or Enrollment in the Contractor's PACE Program is unnecessary. Nothing in this paragraph limits other remedies available to the SDOH or the LDSS under this Agreement.
- E. The Contractor will be afforded due process pursuant to State Law and Regulations 18 NYCRR Part 516 and Article 44 of the PHL.

The Contractor is receiving federal payments under this Contract. The Contractor, and providers paid by the Contractor to fulfill its obligations under this Contract, are subject to certain laws that are applicable to individuals and entities receiving federal funds. The Contractor agrees to inform all providers that payment that they receive are, in whole or in part, from federal funds.

In the event that any provision of this Contract conflicts with the provisions of any statute or regulations applicable to a Contractor, the provisions of the statute or regulations shall have control.

ARTICLE IX

GENERAL PROVISIONS

A. Confidentiality

1. All individually identifiable information relating to Enrollees that is obtained by the Contractor shall be confidential pursuant to the State Public Health Law, the provisions of Section 369 of the State Social Services Law, 42 U.S.C. Section 1396a(a)(7) (Section 1902(a)(7) of the Federal Social Security Act), and regulations promulgated thereunder and shall be used or disclosed by the Contractor pursuant to applicable law.
2. Medical records of Enrollees shall be confidential and shall be disclosed to and by other persons within the Contractor's organization, including Subcontractors, only as necessary to provide health care and quality, peer, or complaint and appeal review of health care under the terms of this Contract, or otherwise in accordance with applicable law.
3. The provisions of this Section shall survive the termination of this Contract and shall bind the Contractor so long as the Contractor maintains any individually identifiable information relating to Enrollees.

B. Relationship of the Parties, Status of the Contractor

The Parties agree that the relationship of Contractor to the Department will be that of an independent contractor. The Parties also agree and acknowledge that Contractor is authorized to operate and to perform its obligations under this Contract pursuant to the provisions of Section 4403-f of New York State Public Health Law, Article 43 of State Insurance Law, and 42 CFR 460. The Parties further agree and acknowledge that Contractor will not, by virtue of its operation, performance of its obligations hereunder, compensation hereunder, or of any other provisions of this Contract be deemed: (1) an agent or instrumentality of the State of New York, the United States, or any agency of either, or (2) a preferred provider organization, third party administrator, or an independent practice association.

C. Employment Practices

1. The Contractor shall comply with the nondiscrimination clause contained in Federal Executive Order 11246, as amended by Federal Executive Order 11375, relating to Equal Employment Opportunity for all persons without regard to race, color, religion, sex or national origin, the implementing rules and regulations prescribed by the Secretary of Labor at 41 CFR Part 60 and with the Executive Law of the State of New York, Section 291-299 thereof and any rules or regulations promulgated in accordance therewith. The Contractor shall likewise be responsible for compliance with the above-mentioned standards by Subcontractors with whom the Contractor enters into a contractual relationship in furtherance of this Contract.
2. The Contractor shall comply with regulations issued by the Secretary of Labor of the United States in 20 Code of Federal Regulations, Part 741, pursuant to the provisions of Executive Order 11758, and with the Federal Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990. The Contractor shall likewise be responsible for compliance with the above-mentioned standards by Subcontractors with whom the Contractor enters into a contractual relationship in furtherance of this Contract.

D. Dispute Resolution

The Contractor and the LDSS shall jointly develop and use a process for resolving disputes with regard to the accuracy of assessments performed for enrollment in voluntary disenrollments and for continued stay decisions when the Enrollee no longer meets the Nursing facility level of care as determined in the annual reassessment review.

E. Assignment

This Contract shall not be assignable by the Contractor without the prior written consent of the Commissioner.

F. Binding Effect

Subject to any provisions hereof restricting assignment, this Contract shall be binding upon and shall inure to the benefit of the Parties and their respective successors and permitted assignees.

G. Limitation on Benefits of this Contract

It is the explicit intention of the Parties that no Enrollee, person or other entity, other than the Parties, is or shall be entitled to bring any action to enforce any provision of this Contract against the other Party, and that the covenants, undertakings, and agreements set forth in this Contract shall be solely for the benefit of, and shall be enforceable only by, the Parties or their respective successors and assignees as permitted hereunder; provided, however, that the covenants, undertakings, and agreements set forth in Article IV, Section J hereof shall be construed for the benefit of the Enrollees.

H. Entire Contract

This Contract (including the Schedules and Appendices hereto) constitutes the entire agreement between the Parties with respect to the subject matter hereof, and it supersedes all prior oral or written agreements, commitments, or understandings with respect to the matters provided for herein. This Contract shall not be deemed to apply to individuals who are not Enrollees.

I. Conflicting Provisions

The PACE Program Agreement will be controlling to the extent there are any inconsistencies between it and the main body of the contract or any of the other appendices. The Standard Contract Clauses for New York State Contracts attached hereto as Appendix A will be controlling over the main body of the contract and its appendices. Article III (F) of the main body of the contract will be controlling over the other provisions of the main body. The main body of the contract, including Article III(F), will be controlling over all appendices except the Appendix A and A-1.

J. Modification

This Contract is subject to amendment or modification only upon mutual consent of the Parties reduced to writing. Attached Appendix X is the form to be used in modification of this Agreement. Any such amendment or modification is not binding on the Parties unless and until approved by the Comptroller of the State of New York.

K. Headings

Article and Section headings contained in this Contract are inserted for convenience of reference only, shall not be deemed to be a part of this Contract for any purpose, and shall not in any way define or affect the meaning, construction, or scope of any of the provisions hereof.

L. Pronouns

All pronouns and any variations thereof shall be deemed to refer to the masculine, feminine, neuter, singular or plural as the identity of the person or entity may require.

M. Notices

All notices permitted or required hereunder shall be in writing and shall be transmitted either:

- (a) via certified or registered United States mail, return receipt requested;
- (b) by facsimile transmission;
- (c) by personal delivery;
- (d) by expedited delivery service; or

(e) by e-mail.

Such notices shall be addressed as follows or to such different addresses as the parties may from time to time designate:

State of New York Department of Health

Name: Andrew Segal
Title: Director, Division of Long Term Care,
Address: Office of Health Insurance Programs
One Commerce Plaza
99 Washington Avenue
Albany, NY 12210

Telephone Number: 518-402-5673
Facsimile Number: 518-474-6961
E-Mail Address: andrew.segal@health.ny.gov

Insert Contractor Name

Name:
Title:
Address:
Telephone Number:
Facsimile Number:
E-Mail Address:

Any such notice shall be deemed to have been given either at the time of personal delivery or, in the case of expedited delivery service or certified or registered United States mail, as of the date of first attempted delivery at the address and in the manner provided herein, or in the case of facsimile transmission or e-mail, upon receipt.

The parties may, from time to time, specify any new or different address in the United States as their address for purpose of receiving notice under this AGREEMENT by giving fifteen (15) days written notice to the other party sent in accordance herewith. The parties agree to mutually designate individuals as their respective representative for the purposes of receiving notices under this AGREEMENT. Additional individuals may be designated in writing by the parties for purposes of implementation and administration/billing, resolving issues and problems, and/or for dispute resolution.

N. Partial Invalidity

Should any provision of this Contract be declared or found to be illegal, invalid, ineffective, unenforceable or void, then each Party shall be relieved of any obligation arising from such provision; the balance of this Contract, if capable of performance, shall remain in full force and effect.

O. Force Majeure

Each Party shall use all efforts to perform its obligations under this Contract but shall be excused for failure to perform or for delay in performance hereunder due to unforeseeable circumstances beyond its reasonable control or which could not have been prevented by it, including but not

limited to, acts of God, floods, hurricanes, earthquakes, acts of war, civil unrest, or embargoes; provided, that acts of any governmental body shall be deemed not to be a force majeure.

P. Survival

The termination or expiration of this Contract shall not affect vested or accrued rights or obligations of the Parties existing as of the date of such termination or expiration or other obligations expressly intended to survive the termination or expiration hereof. Without limiting the generality of the foregoing, the following provisions of this Contract shall survive any expiration or termination of this Contract: entire Article IV, Article VIA, Article VIID, Article IXA and all definitional provisions of this Contract to the extent that they pertain to any other surviving provisions or obligations.

Q. State Standard Appendix A

The Parties agree to be bound by the terms and conditions of the most recent version of the Standard Clauses for New York State Contracts attached hereto and incorporated herein as Appendix A.

R. Indemnification

1. Indemnification by Contractor

- (a) The Contractor shall indemnify, defend and hold harmless the Department, the State, its officers, agents and employees and all their eligible dependents from:
 - (i) any and all claims and losses accruing or resulting from the acts or omissions of the Contractor, Contractor's employees, Subcontractors, material persons, laborers and any other person, firm or corporation furnishing or supplying work, services, materials or supplies in connection with the performance of this Contract;
 - (ii) any and all claims and losses incurred by any person, firm or corporation that may be injured or damaged by the acts or omissions of the Contractor, its officers, agents and employees or Subcontractors including the participating providers, in connection with the performance of this contract;
 - (iii) and against any liability, including costs and expenses, for violation of proprietary rights, copyrights, or rights of privacy, arising out of the publication, translation, reproduction, delivery, performance, use or disposition of any data furnished by the Contractor under this Contract or based on any libelous or otherwise unlawful matter contained in such data.
- (b) The Department shall provide the Contractor with prompt written notice of any claim made against the Department, and the Contractor, at its sole option, shall defend or settle said claim. The Department shall cooperate with the Contractor, to the extent necessary for the Contractor to discharge its obligations hereunder. Notwithstanding the foregoing, the State reserves the right to join any such claim, at its sole expense, when it determines there is an issue of significant public interest.
- (c) The Contractor shall have no obligation hereunder with respect to any claim or cause of action

for damages to persons or property to the extent caused by the Department, its employees or agents, when acting within the course and scope of their employment.

2. Indemnification by The Department

Subject to the availability of lawful appropriations as required by State Finance Law § 41 and consistent with § 8 of the State Court of Claims Act, the Department shall hold the Contractor harmless from and indemnify it for any final judgement of a court of competent jurisdiction to the extent attributable to the negligence of the Department or its officers or employees when acting within the course and scope of their employment. Provisions concerning the Department's responsibility for any claims for liability as may arise during the term of this Contract are set forth in the New York State Court of Claims Act, and any damages arising for such liability shall issue from the New York State Court of Claims Fund or any applicable, annual appropriation of the Legislature of the State of New York.

S. Environmental Compliance

The Contractor shall comply with all applicable standards, orders or regulations issued pursuant to the Clean Air Act, 42 U.S.C. 7401 et seq., and the Federal Water Pollution Control Act, as amended, 33 U.S.C. 1251 et seq. The Contractor shall report violations to the Department, Department of Health and Human Services (DHHS) and to the appropriate Regional Office of the Environmental Protection Agency.

T. Energy Conservation

The Contractor shall comply with any applicable mandatory standards and policies relating to energy efficiency which are contained in the State energy conservation plan issued in compliance with the Energy Policy and Conservation Act of 1975, Pub. L.94-163 42 U.S.C. 6321 et seq., and any amendment thereto.

U. Prohibition on Use of Federal Funds for Lobbying

1. The Contractor agrees, pursuant to Section 1352, Title 31, United States Code, and 45 CFR Part 93 not to expend federally appropriated funds received under this Contract to pay any person for influencing or attempting to influence an officer or employee of an agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan or cooperative agreement. The Contractor agrees to complete and submit the "Certification Regarding Lobbying", attached hereto as Appendix C and incorporated herein, if this Contract exceeds \$100,000.
2. If any funds other than federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of an agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with this Contract or the underlying federal grant and the agreement exceeds \$100,000 the Contractor ~~agrees to shall~~ complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities", ~~attached hereto as Appendix D and incorporated herein,~~ in accordance with its instructions.

3. The Contractor shall include the provisions of this Section in all Subcontracts under this Contract and require that all Subcontractors whose contract exceeds \$100,000 certify and disclose accordingly to the Contractor.

V. Waiver of Breach

No term or provision of this Contract shall be deemed waived and no breach excused, unless such waiver or consent shall be in writing and signed by the Party claimed to have waived or consented. Any consent by a Party to, or waiver of, a breach under this Contract shall not constitute consent to, a waiver of, or excuse for any other, different or subsequent breach.

W. Choice of Law

This Contract shall be interpreted according to the laws of the State of New York. The Contractor shall be required to bring any legal proceeding against the Department or the State arising from this Contract in New York State courts.

X. Executory Provision and Federal Funds

The State Finance Law of the State of New York, Section 112, requires that any contract made by a State Department which exceeds fifteen thousand dollars (\$15,000) in amount be first approved by the Comptroller of the State of New York before becoming effective. The Parties recognize that this Contract is wholly executory and not binding until and unless approved by the Comptroller of the State of New York. The Parties also agree that the effectiveness of this Contract is conditioned upon receipt of any approval required pursuant to federal law to permit full federal financial participation in the costs hereof. Contractor agrees to comply with all applicable federal audit requirements including but not limited to OMB Circular A-87 and other applicable federal rules and procedures concerning use of federal funds.

Y. Renegotiation

In the event any part of this Contract is found to be invalid or unenforceable under applicable law and alters the general scope of contractual performance or a change occurs in applicable State or federal law, rules or regulations or federal or State interpretations thereof which requires alteration of the general scope of contractual performance to remain in compliance therewith, or the Department obtains a waiver of such applicable federal law, rule or regulation, either Party may initiate re-negotiation of the terms and conditions of this Contract to preserve the benefit bargained for. If the Parties are unable to agree on a revision of contractual terms and conditions consistent with the altered scope of contractual performance, either Party may terminate this Contract as of the last day of the month following the month in which written notice of termination is given.

Z. Affirmative Action

The Contractor agrees to comply with all applicable federal and State nondiscrimination statutes including:

1. The Civil Rights Acts of 1964, as amended; Executive Order No. 11246 entitled "Equal Employment Opportunity," as amended by Executive Order 11375, and as supplemented in Department of Labor Regulation 41 CFR Part 60; Executive Law of the State of New York,

Sections 290-299 thereof, and any rules or regulations promulgated in accordance therewith; Section 504 of the Rehabilitation Act of 1973 and the Regulations issued pursuant thereto contained in 45 CFR Part 84 entitled "Nondiscrimination on the Basis of Handicap in Programs and Activities Receiving or Benefiting from Federal Financial Assistance"; and the Americans with Disabilities Act (ADA) of 1990, 42 U.S.C. Section 12116, and regulations issued by the Equal Employment Opportunity Commission which implement the employment provisions of the ADA, set forth at 29 CFR Part 1630.

2. The Contractor is required to demonstrate effective affirmative action efforts and to ensure employment of protected class members. The Contractor must possess and may upon request be required to submit to the Department a copy of an Affirmative Action Plan which is in full compliance with applicable requirements of federal and State statutes.
3. Contractors and Subcontractors shall undertake or continue existing programs of affirmative action to ensure that minority group members and women are afforded equal employment opportunities without discrimination because of race, creed, religion, color, national origin, sex, age, disability or marital status. For these purposes, affirmative action shall apply in the areas of recruitment, employment, job assignment, promotion, upgrading, demotion, transfer, layoff, or termination and rates of pay or other forms of compensation.
4. Prior to the award of a State contract, the Contractor shall submit an Equal Employment Opportunity (EEO) Policy Statement to the Department within the time frame established by the Department.
5. The Contractor's EEO Policy Statement shall contain, but not necessarily be limited to, and the Contractor, as a precondition to entering into a valid and binding State contract, shall, during the performance of the State contract, agree to the following:
 - (a) The Contractor will not discriminate against any employee or applicant for employment because of race, creed, religion, color, national origin, sex, age, sexual orientation, disability or marital status, will undertake or continue existing programs or affirmative action to ensure that minority group members and women are afforded equal employment opportunities without discrimination, and shall make and document its conscientious and active efforts to employ and utilize minority group members and women in its work force on State contracts.
 - (b) The Contractor shall state in all solicitations or advertisements for employees that, in the performance of the State contract, all qualified applicants will be afforded equal employment opportunities without discrimination because of race, creed, religion, color, national origin, sex, age, disability or marital status.
 - (c) At the request of the contracting agency, the Contractor shall request each employment agency, labor union, or authorized representative of workers with which it has a collective bargaining or other agreement or understanding, to furnish a written statement that such employment agency, labor union, or representative will not discriminate on the basis of race, creed, religion, color, national origin, sex, age, sexual orientation, disability or marital status and that such union or representative will affirmatively cooperate in the implementation of the Contractor's obligations herein.
 - (d) Except for construction contracts, prior to an award of a State contract, the Contractor

shall submit to the contracting agency a staffing plan of the anticipated work force to be utilized on the State contract or, where required, information on the Contractor's total work force, including apprentices, broken down by specified ethnic background, gender, and Federal Occupational Categories or other appropriate categories specified by the contracting agency. The form of the staffing plan shall be supplied by the contracting agency.

- (e) After an award of a State contract, the Contractor shall submit to the contracting agency a work force utilization report, in a form and manner required by the agency, of the work force actually utilized on the State contract, broken down by specified ethnic background, gender, and Federal Occupational Categories or other appropriate categories specified by the contracting agency. In the event that the Contractor is found through an administrative or legal action, whether brought in conjunction with this Contract or any other activity engaged in by the Contractor, to have violated any of the laws recited herein in relation to the Contractor's duty to ensure equal employment to protected class members, the Department may, in its discretion, determine that the Contractor has breached this Contract.
- (f) Additionally, the Contractor and any of its Subcontractors shall be bound by the applicable provisions of Article 15-A of the Executive Law, including Section 316 thereof, and any rules or regulations adopted pursuant thereto. The Contractor also agrees that any goal percentages contained in this Contract are subject to the requirements of Article 15-A of the Executive Law and regulations adopted pursuant thereto. For purposes of this Contract the goals established for subcontracting/purchasing with Minority and Women-Owned business enterprises are 0% to 5%. The employment goals for the hiring of protected class persons are 5% to 10%.
- (g) The Contractor shall be required to submit reports as required by the Department in a format determined by the Department, concerning the Contractor's compliance with the above provisions, relating to the procurement of services, equipment and or commodities, subcontracting, staffing plans and for achievement or employment goals. The Contractor agrees to make available to the Department, upon request, the information and data used in compiling such reports. It is the policy of the Department to encourage the employment of qualified applicants/recipients of public assistance by both public organizations and private enterprises who are under contractual agreement to the Department for the provision of goods and services. The Department may require the Contractor to demonstrate how the Contractor has complied or will comply with the aforesaid policy.

AA. Omnibus Procurement Act of 1992

It is the policy of New York State to maximize opportunities for the participation of New York State business enterprises, including minority and women-owned business enterprises as Contractors, Subcontractors, and suppliers on its procurement contracts.

The Omnibus Procurement Act of 1992 requires that by signing this Contract, the Contractor certifies that whenever the total contract is greater than \$1 million:

1. The Contractor has made reasonable efforts to encourage the participation of New York State Business Enterprises as suppliers and Subcontractors on this project, and has retained the documentation of these efforts to be provided upon request to the State;

2. The Contractor has complied with the Federal Equal Opportunity Act of 1972 (Pub. L. 92-261), as amended;
3. The Contractor agrees to make reasonable efforts to provide notification to New York State residents of employment opportunities on this project through listing any such positions with the Job Service Division of the New York State Department of Labor, or providing such notification in such manner as is consistent with existing collective bargaining contracts or agreements. The Contractor agrees to document these efforts and to provide such documentation upon request;
4. The Contractor acknowledges notice that New York State may seek to obtain offset credits from foreign countries as a result of this Contract and agrees to cooperate with the State in these efforts.

BB. Fraud and Abuse

The Contractor shall operate in a manner as to ensure a prompt organizational response to detect offenses and development of corrective action initiatives. The Contractor shall also establish and adhere to a process for reporting to the Department credible information of violations of law by the Contractor, Subcontractors or Enrollees for a determination as to whether criminal, civil or administrative action may be appropriate. With respect to Enrollees, this reporting shall be restricted to credible information on violations of law with respect to enrollment in the plan, or the provision of, or payment for, health services.

CC. Nondiscrimination in Employment in Northern Ireland

In accordance with Chapter 807 of the Laws of 1992, the Contractor agrees that, if it or any individual or legal entity in which the Contractor holds a 10% or greater ownership interest, or any individual or legal entity that holds a 10% or greater ownership in the Contractor, has business operations in Northern Ireland, the Contractor, or such individual or legal entity, shall take lawful steps in good faith to conduct any business operations it has in Northern Ireland in accordance with the MacBride Fair Employment Principles relating to nondiscrimination in employment and freedom of workplace opportunity, and shall permit independent monitoring of its compliance with such Principles.

DD. Contract Insurance Requirements

The Contractor must without expense to the State procure and maintain, for the full term of the Contract, insurance of the kinds and in the amounts hereinafter provided, in insurance companies authorized to do such business in the State of New York covering all operations under this Contract, whether performed by it or by Subcontractors. Before commencing the work, the Contractor shall furnish to the Department of Health a certificate or certificates, in a form satisfactory to said Department, showing that it has complied with the requirements of this section, which certificate or certificates shall state that the policies shall not be changed or canceled until thirty days written notice has been given to said Department. The kinds and amounts of required insurance are:

1. A policy covering the obligations of the Contractor in accordance with the provisions of Chapter 41, Laws of 1914, as amended, known as the Workers' Compensation Law, and the

Contract shall be void and of no effect unless the Contractor procures such policy and maintains it for the full term of the Contract.

2. Policies of Bodily Injury Liability and Property Damage Liability Insurance of the types hereinafter specified, each within limits of not less than \$500,000 for all damages arising out of bodily injury, including death at any time resulting therefrom sustained by one person in any one occurrence, and subject to that limit for that person, not less than \$1,000,000 for all damages arising out of bodily injury, including death at any time resulting therefrom sustained by two or more persons in any one occurrence, and not less than \$500,000 for damages arising out of damage to or destruction of property during any single occurrence and not less than \$1,000,000 aggregate for damages arising out of damage to or destruction of property during the policy period.
 - (a) Contractor's Liability Insurance issued to and covering the liability of the Contractor with respect to all work performed by it under this proposal and the contract.
 - (b) Protective Liability Insurance issued to and covering the liability of the People of the State of New York with respect to all operations under this Contract, by the Contractor or by its Subcontractors, including omissions and supervisory acts of the State.
 - (c) Automobile Liability Insurance issued to and covering the liability of the People of the State of New York with respect to all operations under this Contract, by the Contractor or by its Subcontractors, including omissions and supervisory acts of the State.

EE. Minority And Women Owned Business Policy Statement

The Department recognizes the need to take affirmative action to ensure that Minority and Women Owned Business Enterprises are given the opportunity to participate in the performance of the Department's contracting program. This opportunity for full participation in our free enterprise system by traditionally, socially and economically disadvantaged persons is essential to obtain social and economic equality and improve the functioning of the State economy.

It is the intention of the Department to fully execute the mandate of Executive Order-21 and provide Minority and Women Owned Business Enterprises with equal opportunity to bid on contracts awarded by this agency in accordance with the State Finance Law.

To implement this affirmative action policy statement, the Contractor agrees to file with the Department within 10 days of notice of award, a staffing plan of the anticipated work force to be utilized on this Contract or, where required, information on the Contractor's total work force, including apprentices, broken down by specified ethnic background, gender, and Federal occupational categories or other appropriate categories specified by the Department. The form of the staffing shall be supplied by the Department.

After an award of this Contract, the Contractor agrees to submit to the Department a work force utilization report, in a form and manner required by the Department, of the work force actually utilized on this Contract, broken down by specified ethnic background, gender and Federal occupational categories or other appropriate categories specified by the Department.

FF. Provisions Related to New York State Information Security Breach and Notification

Act

Contractor shall comply with the provisions of the New York State Information Security Breach and Notification Act (General Business Law Section 899-aa; State Technology Law Section 208). Contractor shall be liable for the costs associated with such breach if caused by Contractor's negligent or willful acts or omissions, or the negligent or willful acts or omissions of Contractor's agents, officers, employees or Subcontractors.

GG. Accessibility of State Agency Web-based Intranet and Internet Information and Applications

Any web-based intranet and internet information and applications development, or programming delivered pursuant to the contract or procurement, will comply with New York State Enterprise IT Policy NYS-P08005, *Accessibility of Web-Based Information and Applications*, as such policy or standard may be amended, modified or superseded, which requires that state agency web-based intranet and internet information and applications are accessible to persons with disabilities. Web content must conform to New York State Enterprise IT Policy NYS-P08-005 as determined by quality assurance testing. Such quality assurance testing will be conducted by NYSDOH and the awarded contractor and the results of such testing must be satisfactory to NYSDOH before web content will be considered a qualified deliverable under the contract or procurement.

HH. New York State Tax Law Section 5-a

Section 5-a of the Tax Law, as amended, effective April 26, 2006, requires certain contractors awarded state contracts for commodities, services and technology valued at more than \$100,000 to certify to the New York State Department of Tax and Finance (DTF) that they are registered to collect New York State and local sales and compensating use taxes. The law applies to contracts where the total amount of such contractors' sales delivered into New York State are in excess of \$300,000 for the four quarterly periods immediately preceding the quarterly period in which the certification is made, and with respect to any affiliates and subcontractors whose sales delivered into New York State exceeded \$300,000 for the four quarterly periods immediately preceding the quarterly period in which the certification is made.

This law imposes upon certain contractors the obligation to certify whether or not the contractor, its affiliates, and its subcontractors are required to register to collect sales and compensating use tax and contractors must certify to DTF that each affiliate and subcontractor exceeding such sales threshold is registered with DTF to collect New York State and local sales and compensating use taxes. The law prohibits the State Comptroller, or other approving agencies, from approving a contract awarded to an offerer meeting the registration requirements but who is not so registered in accordance with the law.

Contractor must complete and submit directly to the New York State Taxation and Finance, Contractor Certification Form ST-220-TD. Unless the information upon which the ST-220-TD is based changes, this form only needs to be filed once with the DTF. If the information changes for the contractor, its affiliates(s), or its subcontractors(s), a new form (ST-220-TD) must be filed with the DTF.

Contractor must complete and submit to the Department of Health the form ST-220-CA certifying that the contractor filed the ST-220-TD with DTF. Failure to make either of these filings may render an offerer non-responsive and non-responsive. Offerers shall take the necessary steps to

provide properly certified forms within a timely manner to ensure compliance with the law.

II. Provisions Related to New York State Procurement Lobbying Law

The State reserves the right to terminate this Contract in the event it is found that the certification filed by the Contractor in accordance with New York State Finance Law § 139-k was intentionally false or intentionally incomplete. Upon such finding, the State may exercise its termination right by providing written notification to the Contractor in accordance with the written notification terms of the Contract.

JJ. Piggybacking

New York State Finance Law Section 163(10)(e) [see also <http://www.ogs.state.ny.us/procurecounc/pgbguidelines.asp>] allows the Commissioner of the NYS Office of General Services to consent to the use of this contract by other New York State Agencies, and other authorized purchasers, subject to conditions and the Contractor's consent.

KK. Lead Guidelines

All products supplied pursuant to this agreement shall meet local, state and federal regulations, guidelines and action levels for lead as they exist at the time of the State's acceptance of this contract.

LL. Payment

Payment for claims/invoices submitted by the Contractor shall only be rendered electronically unless payment by paper check is expressly authorized by the Commissioner, in the Commissioner's sole discretion, due to extenuating circumstances. Such electronic payment shall be made in accordance with ordinary State procedures and practices. The Contractor shall comply with the State Comptroller's procedures to authorize electronic payments. Authorization forms are available at the State Comptroller's website at www.osc.state.ny.us/epay/index.htm, by email at epunit@osc.state.ny.us or by telephone at 518-474-6019. The Contractor acknowledges that it will not receive payment on any claims/invoices submitted under this Agreement if it does not comply with the State Comptroller's electronic payment procedures, except where the Commissioner has expressly authorized payment by paper check as set forth above.

In addition to the Electronic Payment Authorization Form, a Substitute Form W-9, must be on file with the Office of the State Comptroller, Bureau of Accounting Operations. Additional information and procedures for enrollment can be found at <http://www.osc.state.ny.us/epay>.

Completed W-9 forms should be submitted to the following address:

NYS Office of the State Comptroller
Bureau of Accounting Operations
Warrant & Payment Control Unit
110 State Street, 9th Floor
Albany, NY 12236

MM. M/WBE Utilization Plan for Subcontracting and Purchasing

The Department of Health (DOH) encourages the use of Minority and/or Women Owned Business Enterprises (M/WBEs) for any subcontracting or purchasing related to this contract. Contractors who are not currently a New York State certified M/WBE must define the portion of all consumable products and personnel required for this proposal that will be sourced from a M/WBE. The amount must be stated in total dollars and as a percent of the total cost necessary to fulfill the Agreement requirements. Supportive documentation must include a detailed description of work that is required including products and services.

The goal for usage of M/WBEs is at least 10% of monies used for contract activities. In order to assure a good-faith effort to attain this goal, the STATE requires that Contractors complete the M/WBE Utilization Plan and submit this Plan.

Contractors that are New York State certified MBEs or WBEs are not required to complete this form. Instead, such Contractors must simply provide evidence of their certified status.

Failure to submit the above referenced Plan (or evidence of certified M/WBE status) will result in disqualification of the vendor from consideration for award.

NN. On-going Responsibility

1. General Responsibility Language

The Contractor shall at all times during the Contract term remain responsible. The Contractor agrees, if requested by the Commissioner of Health or his or her designee, to present evidence of its continuing legal authority to do business in New York State, integrity, experience, ability, prior performance, and organizational and financial capacity.

2. Suspension of Work (for Non-Responsibility)

The Commissioner of Health or his or her designee, in his or her sole discretion, reserves the right to suspend any or all activities under this Contract, at any time, when he or she discovers information that calls into question the responsibility of the Contractor. In the event of such suspension, the Contractor will be given written notice outlining the particulars of such suspension. Upon issuance of such notice, the Contractor must comply with the terms of the suspension order. Contract activity may resume at such time as the Commissioner of Health or his or her designee issues a written notice authorizing a resumption of performance under the Contract.

3. Termination (for Non-Responsibility)

Upon written notice to the Contractor, and a reasonable opportunity to be heard with appropriate Department of Health officials or staff, the Contract may be terminated by the Commissioner of Health or his or her designee at the Contractor's expense where the Contractor is determined by the Commissioner of Health or his or her designee to be non-responsible. In such event, the Commissioner of Health or his or her designee may complete the contractual requirements in any manner he or she may deem advisable and pursue available legal or equitable remedies for breach.

OO. Language Access and Translation Requirements

1. The Contractor is required to reimburse Article 28 outpatient departments, diagnostic and treatment centers, federally qualified health centers, and office-based practitioners to provide medical language interpreter services for Enrollees with limited English proficiency (LEP) and communication services for people who are deaf and hard of hearing;
 - a) An Enrollee with limited English proficiency shall be defined as an individual whose primary language is not English and who cannot speak, read, write or understand the English language at a level sufficient to permit the Enrollee to interact effectively with health care providers and their staff. The need for medical language interpreter services must be documented in the medical record; and
 - b) Language interpreter services must be provided during scheduled appointments and scheduled encounters by a third party interpreter who is either employed by or contracts with the medical provider. These services may be provided either face-to-face, by telephone, and/or by video remote interpreter technology. The interpreter must demonstrate competency and skills in medical interpretation techniques, ethics and terminology. It is recommended, but not required, that such individuals be certified by the National Board of Certification for Medical Interpreters (NBCMI) or be qualified by New York State wherever possible.
- iv. The Contractor shall advise Enrollees that they are entitled to receive language interpretation services upon request and at no charge to the Enrollee.
2. For all foreign language translations of Outreach/Advertising material, the Contractor must submit a letter from the translation service that attests that the translator has used its best efforts to accurately translate the material into the specified languages. At a minimum, the translation service must perform a reverse translation (translate the foreign language version back into English and compare to original document).
 - a) Translated materials must be written in 12 point type at a minimum and prose written in clear, simple, understandable language at the 4th to 6th grade reading level.
3. The Contractor must submit to the Department for prior approval a description of how the Contractor will provide information and annual notification to its Enrollees as required, including the methods the Contractor will use to provide information to Applicants and Enrollees who speak other than English as a primary language including provision of oral interpretation service for any language.

PP. High Cost High Need Risk Pool

During the period of April 1, 2014 through March 31, 2015, the Contractor will participate in a High Cost High Need Risk Pool which will be administered by the Department. The purpose of the Pool is to mitigate the additional costs incurred by MCOs which have a disproportionate share of high needs members.

Disproportionate share is defined as a member mix, on a percentage basis, that is greater than average. High needs members are defined as those members requiring 12-24 hours per day of

personal care service or community-based ventilator patients, as identified in encounter data or other reporting requirements provided by the Contractor as defined by the Department or entity designated by the Department.

The Pool will be funded by a 2% withholding from the monthly capitation payments which would otherwise be payable to the Plan for enrollments during the period of April 1, 2014 through March 31, 2015. All withheld funds will be distributed by the Department to MCOS which have a disproportionate share of high needs members. In the event that no disproportionate share exists, the Department shall remit payment of all withheld funds in its entirety.

The Department will evaluate the use of the Pool and other financing arrangements to validate that fund payments are not duplicative of each other. Capitation rates resulting from the implementation of the Pool, reflecting a 2% withholding and/or reflecting distribution of withheld funds, shall be certified to be actuarially sound in accordance with 42 CFR §438.6(c).

The Department shall have the right to terminate the Pool if another method to mitigate the risk of high needs patients is implemented, or if the Department determines for any other reason that the Pool is no longer necessary.

QQ. Modification of Benefit Package Services

The parties acknowledge and accept that the Department has the right to make modifications to the Benefit Package, with advance written notice to the Contractor of at least sixty (60) days. Such modifications include expansions of and restrictions to covered benefits as referenced in 42 CFR §460.92. Such modifications will be made as necessary to implement statewide Medicaid program initiatives, including Medicaid Redesign initiatives.

RR. Cultural and Linguistic Competence

- 1) The Contractor shall promote and ensure the delivery of services in a culturally competent manner to all Enrollees, including, but not limited to, those with limited English proficiency and diverse cultural and ethnic backgrounds as well as Enrollees with diverse sexual orientations, gender identities and members of diverse faith communities. For the purposes of this Contract, cultural competence means having the capacity to function effectively within the context of the cultural beliefs, behaviors, and needs presented by Enrollees and their communities across all levels of the Contractor's organization.
- 2) In order to comply with this section, the Contractor shall:
 - a) Maintain an inclusive, culturally competent provider network;
 - b) Adopt policies and procedures that incorporate the importance of honoring Enrollees' beliefs, sensitivity to cultural diversity, fostering respect for Enrollees' culture and cultural identity, and eliminating cultural disparities;
 - c) Maintain a Cultural Competence component of the Contractor's Internal Quality Assurance program;
 - d) Develop and execute a comprehensive cultural competence plan based on Culturally and Linguistically Appropriate Services (CLAS) national standards of the US

Department of Health and Human Services, Office of Minority Health and managed through the Contractor's Internal Quality Assurance Program;

- e) Perform internal cultural competence activities including, but not limited to conducting:
 - i. Organization-wide cultural competence self-assessment;
 - ii. Community needs assessments to identify threshold populations in each Service Area in which the Contractor operates; and
 - iii. Quality improvement projects to improve cultural competence and reduce disparities, informed by such assessments and CLAS standards.
 - f) Facilitate annual training in cultural competence for all the Contractor's staff members. All elements of the curriculum shall be consistent with and/or reflect CLAS national standards. The Contractor's cultural competence training materials are subject to the review and approval by the State.
- 3) The Contractor shall ensure the cultural competence of its provider network by requiring Participating Providers to certify, on an annual basis, completion of State-approved cultural competence training curriculum, including training on the use of interpreters, for all Participating Providers' staff who have regular and substantial contact with Enrollees. The State will provide cultural competence training materials to the Contractor and providers upon request.

SS. Telehealth

Effective January 1, 2016, health care services delivered by telehealth are covered by the Contractor. Telehealth delivered services use electronic information and communication technologies by telehealth providers to deliver health care services, which include the assessment, diagnosis, consultation, treatment, education, care management and/or self-management of an Enrollee. Telehealth provider means: physician, physician assistant, dentist, nurse practitioner, registered professional nurse (only when such nurse is receiving patient-specific health information or medical data at a distant site by means of remote patient monitoring), podiatrist, optometrist, psychologist, social worker, speech language pathologist, audiologist, midwife, certified diabetes educator, certified asthma educator, certified genetic counselor, hospital, home care agency, hospice, or any other provider determined by the Commissioner of Health pursuant to regulation. The Contractor is responsible for covering services in the benefit package that are delivered by telehealth in accordance with Section 2999-cc of the Public Health Law.

APPENDIX A-1
PACE PROGRAM AGREEMENT

APPENDIX A
STANDARD CLAUSES FOR NEW YORK STATE CONTRACTS

APPENDIX B

New York State Department of Health Guidelines for Contractor Compliance with the Federal Americans with Disabilities Act

I. OBJECTIVES

Title II of the Americans With Disabilities Act (ADA) and Section 504 of the Rehabilitation Act of 1973 (Section 504) provides that no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or denied access to the benefits of services, programs or activities of a public entity, or be subject to discrimination by such an entity. Public entities include State and local government and ADA and Section 504 requirements extend to all programs and services provided by State and local government. Since Medicaid is a government program, health services provided through Medicaid Managed Care, including Managed Long Term Care, must be accessible to all that qualify for them.

MCO responsibilities for compliance with the ADA are imposed under Title II and Section 504 when, as a contractor in a Medicaid program, a plan is providing a government service. If an individual provider under contract with the MCO is not accessible, it is the responsibility of the MCO to make arrangements to assure that alternative services are provided. The MCO may determine it is expedient to make arrangements with other providers, or to describe reasonable alternative means and methods to make these services accessible through its existing Participating Providers. The goals of compliance with ADA Title II requirements are to offer a level of services that allows people with disabilities access to the program in its entirety, and the ability to achieve the same health care results as any Enrollee.

MCO responsibilities for compliance with the ADA are also imposed under Title III when the MCO functions as a public accommodation providing services to individuals (e.g. program areas and sites such as Marketing, education, member services, orientation, Complaints and Appeals). The goals of compliance with ADA Title III requirements are to offer a level of services that allows people with disabilities full and equal enjoyment of the goods, services, facilities or accommodations that the entity provides for its customers or clients. New and altered areas and facilities must be as accessible as possible. Whenever MCOs engage in new construction or renovation, compliance is also required with accessible design and construction standards promulgated pursuant to the ADA as well as State and local laws. Title III also requires that public accommodations undertake “readily achievable barrier removal” in existing facilities where architectural and communications barriers can be removed easily and without much difficulty or expense.

The State uses Plan Qualification Standards to qualify MCOs for participation in the Managed Long Term Care Program pursuant to the State’s responsibility to assure program access to all Enrollees, the Plan Qualification Standards require each MCO to submit an ADA Compliance Plan that describes in detail how the MCO will make services, programs and activities readily accessible and useable by individuals with disabilities. In the event that certain program sites are not readily accessible, the MCO must describe reasonable alternative methods for making the services or activities accessible and usable.

The objectives of these guidelines are threefold:

- To ensure that MCOs take appropriate steps to measure access and assure program accessibility for persons with disabilities;
- To provide a framework for MCOs as they develop a plan to assure compliance with the Americans with Disabilities Act (ADA); and
- To provide standards for the review of the MCO Compliance Plans.

These guidelines include a general standard followed by a discussion of specific considerations and suggestions of methods for assuring compliance. Please be advised that, although these guidelines and any subsequent reviews by State and local governments can give the Contractor guidance, it is ultimately the Contractor's obligation to ensure that it complies with its Contractual obligations, as well as with the requirements of the ADA, Section 504, and other federal, state and local laws. Other federal, state and local statutes and regulations also prohibit discrimination on the basis of disability and may impose requirements in addition to those established under ADA. For example, while the ADA covers those impairments that "substantially" limit one or more of the major life activities of an individual, New York City Human Rights Law deletes the modifier "substantially".

II. DEFINITIONS

- A. "Auxiliary aids and services" may include qualified interpreters, note takers, computer-aided transcription services, written materials, telephone handset amplifiers, assistive listening systems, telephones compatible with hearing aids, closed caption decoders, open and closed captioning, telecommunications devices for Enrollees who are deaf or hard of hearing (TTY/TDD), video text displays, and other effective methods of making aurally delivered materials available to individuals with hearing impairments; qualified readers, taped texts, audio recordings, Braille materials, large print materials, or other effective methods of making visually delivered materials available to individuals with visual impairments.
- B. "Disability" means a mental or physical impairment that substantially limits one or more of the major life activities of an individual; a record of such impairment; or being regarded as having such an impairment.

III. SCOPE OF CONTRACTOR COMPLIANCE PLAN

The MCO Compliance Plan must address accessibility to services at MCO's program sites, including both Participating Provider sites and MCO facilities intended for use by Enrollees.

IV. PROGRAM ACCESSIBILITY

Public programs and services, when viewed in their entirety must be readily accessible to and useable by individuals with disabilities. This standard includes physical access, non-discrimination in policies and procedures and communication. Communications with individuals with disabilities are required to be as effective as communications with others. The MCO Compliance Plan must include a detailed description of how MCO services, programs, and activities are readily accessible and usable by individuals with disabilities. In the event that full physical accessibility is not readily available for people with disabilities, the MCO Compliance Plan will describe the steps or actions the MCO will take to assure accessibility to services equivalent to those offered at the inaccessible

facilities.

A. PRE-ENROLLMENT MARKETING AND EDUCATION

STANDARD FOR COMPLIANCE

Marketing staff, activities and materials will be made available to persons with disabilities. Marketing materials will be made available in alternative formats (such as Braille, large print, and audiotapes) so that they are readily usable by people with disabilities.

SUGGESTED METHODS FOR COMPLIANCE

1. Activities held in physically accessible location, or staff at activities available to meet with person in an accessible location as necessary
2. Materials available in alternative formats, such as Braille, large print, audio tapes
3. Staff training which includes training and information regarding attitudinal barriers related to disability
4. Activities and fairs that include sign language interpreters or the distribution of a written summary of the marketing script used by plan marketing representatives
5. Enrollee health promotion material/activities targeted specifically to persons with disabilities (e.g. secondary infection prevention, decubitus prevention, special exercise programs, etc.)
6. Policy statement that Marketing Representatives will offer to read or summarize to blind or vision impaired individuals any written material that is typically distributed to all Enrollees
7. Staff/resources available to assist individuals with cognitive impairments in understanding materials

COMPLIANCE PLAN SUBMISSION

1. A description of methods to ensure that the MCO's Marketing presentations (materials and communications) are accessible to persons with auditory, visual and cognitive impairments
2. A description of the MCO's policies and procedures, including Marketing training, to ensure that Marketing Representatives neither screen health status nor ask questions about health status or prior health care services

B. MEMBER SERVICES DEPARTMENT

Member services functions include the provision to Enrollees of information necessary to make informed choices about treatment options, to effectively utilize the health care resources, to assist Enrollees in making appointments, and to field questions and Complaints, to assist Enrollees with the Complaint process.

B1. ACCESSIBILITY

STANDARD FOR COMPLIANCE

Member Services sites and functions will be made accessible to and usable by,

people with disabilities.

SUGGESTED METHODS FOR COMPLIANCE (include, but are not limited to those identified below):

1. Exterior routes of travel, at least 36" wide, from parking areas or public transportation stops into the Contractor's facility
2. If parking is provided, spaces reserved for people with disabilities, pedestrian ramps at sidewalks, and drop-offs
3. Routes of travel into the facility are stable, slip-resistant, with all steps > ½" ramped, doorways with minimum 32" opening
4. Interior halls and passageways providing a clear and unobstructed path or travel at least 36" wide to bathrooms and other rooms commonly used by Enrollees
5. Waiting rooms, restrooms, and other rooms used by Enrollees are accessible to people with disabilities
6. Sign language interpreters and other auxiliary aids and services provided in appropriate circumstances
7. Materials available in alternative formats, such as Braille, large print, audio tapes
8. Staff training which includes sensitivity training related to disability issues [Resources and technical assistance are available through the NYS Office of Advocate for Persons with Disabilities - V/TTY (800) 522-4369; and the NYC Mayor's Office for People with Disabilities - (212) 788-2830 or TTY (212)788-2838]
9. Availability of activities and educational materials tailored to specific conditions/illnesses and secondary conditions that affect these populations (e.g. secondary infection prevention, decubitus prevention, special exercise programs, etc.)
10. MCO staff trained in the use of telecommunication devices for Enrollees who are deaf or hard of hearing (TTY/TDD) as well as in the use of NY Relay for phone communication
11. New Enrollee orientation available in audio or by interpreter services
12. Policy that when member services staff receive calls through the NY Relay, they will offer to return the call utilizing a direct TTY/TDD connection

COMPLIANCE PLAN SUBMISSION

1. A description of accessibility to the member services department or reasonable alternative means to access member services for Enrollees using wheelchairs (or other mobility aids)
2. A description of the methods the member services department will use to communicate with Enrollees who have visual or hearing impairments, including any necessary auxiliary aid/services for Enrollees who are deaf or hard of hearing, and TTY/TDD technology or NY Relay service available through a toll-free telephone number
3. A description of the training provided to the member services staff to assure that staff adequately understands how to implement the requirements of the program, and of these guidelines, and are sensitive to the needs of persons with disabilities

B2. IDENTIFICATION OF ENROLLEES WITH DISABILITIES

STANDARDS FOR COMPLIANCE

The Contractor must have in place satisfactory methods/guidelines for identifying persons at risk of, or having, chronic diseases and disabilities and determining their specific needs in terms of specialist physician referrals, durable medical equipment, medical supplies, home health services etc. The Contractor may not discriminate against a Prospective Enrollee based on his/her current health status or anticipated need for future health care. The Contractor may not discriminate on the basis of disability, or perceived disability of an Enrollee or their family member.

SUGGESTED METHODS FOR COMPLIANCE

1. Appropriate post Enrollment health screening for each Enrollee, using an appropriate health screening tool
2. Patient profiles by condition/disease for comparative analysis to national norms, with appropriate outreach and education
3. Process for follow-up of needs identified by initial screening; e.g. referrals, assignment of case manager, assistance with scheduling/keeping appointments
4. Enrolled population disability assessment survey
5. Process for Enrollees who acquire a disability subsequent to Enrollment to access appropriate services

COMPLIANCE PLAN SUBMISSION

A description of how the Contractor will identify special health care, physical access or communication needs of Enrollees on a timely basis, including but not limited to the health care needs of Enrollees who:

- are blind or have visual impairments, including the type of auxiliary aids and services required by the Enrollee
- are deaf or hard of hearing, including the type of auxiliary aids and services required by the Enrollee
- have mobility impairments, including the extent, if any, to which they can ambulate
- have other physical or mental impairments or disabilities, including cognitive impairments
- have conditions which may require more intensive case management

B3. NEW ENROLLEE ORIENTATION

STANDARD FOR COMPLIANCE

Enrollees will be given information sufficient to ensure that they understand how to access medical care through the plan. This information will be made accessible to and usable by people with disabilities.

SUGGESTED METHODS FOR COMPLIANCE

1. Activities held in physically accessible location, or staff at activities available to meet with person in an accessible location as necessary
2. Materials available in alternative formats, such as Braille, large print, audio tapes
3. Staff training which includes sensitivity training related to disability issues [Resources and technical assistance are available through the NYS Office of Advocate for Persons with Disabilities - V/TTY (800) 522-4369; and the NYC Mayor's Office for People with Disabilities - (212) 788-2830 or TTY (212)788-2838]
4. Activities and fairs that include sign language interpreters or the distribution of a written summary of the Marketing script used by plan marketing representatives
5. Include in written/audio materials available to all Enrollees information regarding how and where people with disabilities can access help in getting services, for example help with making appointments or for arranging special transportation, an interpreter or assistive communication devices
6. Staff/resources available to assist individuals with cognitive impairments in understanding materials

COMPLIANCE PLAN SUBMISSION

1. A description of how the MCO will advise Enrollees with disabilities, during the new Enrollee orientation on how to access care
2. A description of how the MCO will assist new Enrollees with disabilities (as well as current Enrollees who acquire a disability) in selecting or arranging an appointment with a Primary Care Practitioner (PCP)
 - This should include a description of how the MCO will assure and provide notice to Enrollees who are deaf or hard of hearing, blind or who have visual impairments, of their right to obtain necessary auxiliary aids and services during appointments and in scheduling appointments and follow-up treatment with Participating Providers
 - In the event that certain provider sites are not physically accessible to Enrollees with mobility impairments, the MCO will assure that reasonable alternative site and services are available
3. A description of how the MCO will determine the specific needs of an Enrollee with or at risk of having a disability/chronic disease, in terms of specialist physician referrals, durable medical equipment (including assistive technology and adaptive equipment), medical supplies and home health services and will assure that such contractual services are provided
4. A description of how the MCO will identify if an Enrollee with a disability requires on-going mental health services and how the MCO will encourage early entry into treatment
5. A description of how the MCO will notify Enrollees with disabilities as to how to access transportation, where applicable

B4. COMPLAINTS, COMPLAINTS AND APPEALS

STANDARDS FOR COMPLIANCE

The MCO will establish and maintain a procedure to protect the rights and interests of both Enrollees and the managed long term care plans by receiving, processing, and resolving Complaints and Appeals in an expeditious manner, with the goal of ensuring resolution of Complaints/Appeals and access to appropriate services as rapidly as possible.

All Enrollees must be informed about the Grievance System within their plan and the procedure for filing Complaints and/or Appeals. This information will be made available through the Member Handbook, the Department's toll-free Complaint line [1-(800) 206-8125] and the plan's Complaint process annually, as well as when the MCO denies a benefit or referral. The MCO will inform Enrollees of: the MCO's procedures; Enrollees' right to contact the LDSS or the Department with a Complaint, and to file an Appeal or request a fair hearing; the right to appoint a designee to handle a Complaint or Appeal; and the toll free Complaint line. The MCO will maintain designated staff to take and process complaints, and be responsible for assisting Enrollees in complaint resolution.

The MCO will make all information regarding the Grievance System available to and usable by people with disabilities, and will assure that people with disabilities have access to sites where Enrollees typically file Complaints and requests for Appeals.

SUGGESTED METHODS FOR COMPLIANCE

1. Toll-free Complaint phone line with TDD/TTY capability
2. Staff trained in Complaint process, and able to provide interpretive or assistive support to Enrollee during the Complaint process
3. Notification materials and Complaint forms in alternative formats for Enrollees with visual or hearing impairments
4. Availability of physically accessible sites, e.g. member services department sites
5. Assistance for individuals with cognitive impairments

COMPLIANCE PLAN SUBMISSION

1. A description of how the MCO's Complaint and Appeal procedures shall be accessible for persons with disabilities, including:
 - procedures for Complaints and Appeals to be made in person at sites accessible to persons with mobility impairments
 - procedures accessible to persons with sensory or other impairments who wish to make verbal Complaints or Appeals, and to communicate with such persons on an ongoing basis as to the status of their Complaints and rights to further appeals
 - description of methods to ensure notification material is available in alternative formats for Enrollees with vision and hearing impairments
2. A description of how the Contractor monitors Complaints and Appeals related to people with disabilities.

C. CASE MANAGEMENT

STANDARD FOR COMPLIANCE

MCOs must have in place adequate case management systems to identify the service needs of all Enrollees, including Enrollees with chronic illness and Enrollees with disabilities, and ensure that medically necessary covered benefits are delivered on a timely basis. These systems must include procedures for standing referrals, specialists as PCPs, and referrals to specialty centers for Enrollees who require specialized medical care over a prolonged period of time (as determined by a treatment plan approved by the MCO in consultation with the primary care provider, the designated specialist and the Enrollee or his/her designee), out-of-network referrals and continuation of existing treatment relationships with out-of-network providers (during transitional period).

SUGGESTED METHODS FOR COMPLIANCE

1. Procedures for requesting specialist physicians to function as PCP
2. Procedures for requesting standing referrals to specialists and/or specialty centers, out-of-network referrals, and continuation of existing treatment relationships
3. Procedures to meet Enrollee needs for, durable medical equipment, medical supplies, home visits as appropriate
4. Appropriately trained MCO staff to function as case managers for special needs populations, or sub-contract arrangements for case management
5. Procedures for informing Enrollees about the availability of case management services

COMPLIANCE PLAN SUBMISSION

1. A description of the MCO case management program for people with disabilities, including case management functions, procedures for qualifying for and being assigned a case manager, and description of case management staff qualifications
2. A description of the MCO's model protocol to enable Participating Providers, at their point of service, to identify Enrollees who require a case manager
3. A description of the MCO's protocol for assignment of specialists as PCP, and for standing referrals to specialists and specialty centers, out-of-network referrals and continuing treatment relationships
4. A description of the MCO's notice procedures to Enrollees regarding the availability of case management services, specialists as PCPs, standing referrals to specialists and specialty centers, out-of-network referrals and continuing treatment relationships

D. PARTICIPATING PROVIDERS

STANDARD FOR COMPLIANCE

MCO's networks will include all the provider types necessary to furnish the Benefit Package, to assure appropriate and timely health care to all Enrollees, including those with chronic illness and/or disabilities. Physical accessibility is not limited to entry to a provider site, but also includes access to services within the site, e.g. exam tables and medical equipment.

SUGGESTED METHODS FOR COMPLIANCE

1. Process for the MCO to evaluate provider network to ascertain the degree of provider accessibility to persons with disabilities, to identify barriers to access and required modifications to policies/procedures
2. Model protocol to assist Participating Providers, at their point of service, to identify Enrollees who require case manager, audio, visual, mobility aids, or other accommodations
3. Model protocol for determining needs of Enrollees with mental disabilities
4. Use of Wheelchair Accessibility Certification Form (see attached)
5. Submission of map of physically accessible sites
6. Training for providers re: compliance with Title III of ADA, e.g. site access requirements for door widths, wheelchair ramps, accessible diagnostic/treatment rooms and equipment; communication issues; attitudinal barriers related to disability, etc. [Resources and technical assistance are available through the NYS Office of Advocate for Persons with Disabilities -V/TTY (800) 522-4369; and the NYC Mayor's Office for People with Disabilities - (212) 788-2830 or TTY (212) 788-2838].
7. Use of ADA Checklist for Existing Facilities and NYC Addendum to OAPD ADA Accessibility Checklist as guides for evaluating existing facilities and for new construction and/or alteration.

COMPLIANCE PLAN SUBMISSION

1. A description of how the MCO will ensure that its Participating Provider network is accessible to persons with disabilities. This includes the following:
 - Policies and procedures to prevent discrimination on the basis of disability or type of illness or condition
 - Identification of Participating Provider sites which are accessible by people with mobility impairments, including people using mobility devices. If certain provider sites are not physically accessible to persons with disabilities, the MCO shall describe reasonable, alternative means that result in making the provider services readily accessible.
 - Identification of Participating Provider sites which do not have access to sign language interpreters or reasonable alternative means to communicate with Enrollees who are deaf or hard of hearing; and for those sites describe reasonable alternative methods to ensure that services will be made accessible
 - Identification of Participating Providers which do not have adequate communication systems for Enrollees who are blind or have vision impairments (e.g. raised symbol and lettering or visual signal appliances), and for those sites describe reasonable alternative methods to ensure that services will be made accessible
2. A description of how the MCO's specialty network is sufficient to meet the needs of Enrollees with disabilities
3. A description of methods to ensure the coordination of out-of-network providers to meet the needs of the Enrollees with disabilities
 - This may include the implementation of a referral system to ensure that the health care needs of Enrollees with disabilities are met appropriately
 - MCO shall describe policies and procedures to allow for the continuation of existing relationships with out-of-network providers, when in the best interest of the Enrollee with a disability

4. Submission of the ADA Compliance Summary Report or MCO statement that data submitted to the Department is an accurate reflection of each network's physical accessibility

E. POPULATIONS WITH SPECIAL HEALTH CARE NEEDS

STANDARD FOR COMPLIANCE

MCOs will have satisfactory methods for identifying persons at risk of, or having, chronic disabilities and determining their specific needs in terms of specialist physician referrals, durable medical equipment, medical supplies, home health services, etc. MCOs will have satisfactory systems for coordinating service delivery and, if necessary, procedures to allow continuation of existing relationships with out-of-network provider for course of treatment.

SUGGESTED METHODS FOR COMPLIANCE

1. Procedures for requesting standing referrals to specialists and/or specialty centers, specialist physicians to function as PCP, out-of-network referrals, and continuation of existing relationships with out-of-network providers for course of treatment
2. Linkages with behavioral health agencies, disability and advocacy organizations, etc.
3. Adequate network of providers and sub-specialists and contractual relationships with tertiary institutions
4. Procedures for assuring that these populations receive appropriate diagnostic work-ups on a timely basis
5. Procedures for assuring that these populations receive appropriate access to durable medical equipment on a timely basis
6. Procedures for assuring that these populations receive appropriate allied health professionals (Physical, Occupational and Speech Therapists, Audiologists) on a timely basis
7. State designation as a Well Qualified Plan to serve the OMRDD population and look-alikes

COMPLIANCE PLAN SUBMISSION

A description of arrangements to ensure access to specialty care providers and centers in and out of New York State, standing referrals, specialist physicians to function as PCP, out-of-network referrals, and continuation of existing relationships (out-of-network) for diagnosis and treatment of rare disorders

F. ADDITIONAL ADA RESPONSIBILITIES FOR PUBLIC ACCOMMODATIONS

Please note that Title III of the ADA applies to all non-governmental providers of health care. Title III of the Americans with Disabilities Act prohibits discrimination on the basis of disability in the full and equal enjoyment of goods, services, facilities, privileges, advantages or accommodations of any place of public accommodation. A public accommodation is a private entity that owns, leases or leases to, or operates a place of public accommodation. Places of public accommodation identified by the ADA include, but are not limited to, stores (including pharmacies) offices (including doctors' offices),

hospitals, health care providers, and social service centers.

New and altered areas and facilities must be as accessible as possible. Barriers must be removed from existing facilities when it is readily achievable, defined by the ADA as easily accomplishable without much difficulty or expense. Factors to be considered when determining if barrier removal is readily achievable include the cost of the action, the financial resources of the site involved, and, if applicable, the overall financial resources of any parent corporation or entity. If barrier removal is not readily achievable, the ADA requires alternate methods of making goods and services available. New facilities must be accessible unless structurally impracticable.

Title III also requires places of public accommodation to provide any auxiliary aids and services that are needed to ensure equal access to the services it offers, unless a fundamental alteration in the nature of services or an undue burden would result. Auxiliary aids include but are not limited to qualified sign interpreters, assistive listening systems, readers, large print materials, etc. Undue burden is defined as “significant difficulty or expense”. The factors to be considered in determining “undue burden” include, but are not limited to, the nature and cost of the action required and the overall financial resources of the provider. “Undue burden” is a higher standard than “readily achievable” in that it requires a greater level of effort on the part of the public accommodation.

Please note also that the ADA is not the only law applicable for people with disabilities. In some cases, State or local laws require more than the ADA. For example, New York City’s Human Rights Law, which also prohibits discrimination against people with disabilities, includes people whose impairments are not as “substantial” as the narrower ADA and uses the higher “undue burden” (“reasonable”) standard where the ADA requires only that which is “readily achievable”. New York City’s Building Code does not permit access waivers for newly constructed facilities and requires incorporation of access features as existing facilities are renovated. Finally, the State Hospital code sets a higher standard than the ADA for provision of communication (such as sign language interpreters) for services provided at most hospitals, even on an outpatient basis.

APPENDIX C

CERTIFICATION REGARDING LOBBYING

The undersigned certified, 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 Contractor 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 awarding 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.
2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for 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 entering into 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 Contractor shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.
3. The Contractor shall include the provisions of this section in all provider Agreements under this Agreement and require all Participating Providers whose provider agreements exceed \$100,000 to certify and disclose accordingly to the Contractor.
4. 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 imposed pursuant to U.S.C. 1352 The failure to file the required certification shall subject the violator to a civil penalty of not less than \$10,000 and nor more than \$100,000 for each such failure.

Date: _____

Signature: _____

Printed Name: _____

Title: _____

Organization: _____

APPENDIX D

~~Standard Form LLL Disclosure of Lobbying Activities~~ RESERVED

APPENDIX E-1

Proof of Workers' Compensation Coverage

APPENDIX E-2

Proof of Disability Insurance Coverage

APPENDIX F

DEFINITIONS

834 Electronic Data Interchange Transmission file (834 File). A HIPAA 5010 compliant transaction enacted as part of the Affordable Care Act (P.L. 111-148 and 111-152). The 834 is an electronic Benefit Enrollment and Maintenance document generated by the New York State of Health. The 834 file contains new enrollments, changes in enrollments, reinstatement of enrollments and disenrollments.

Adult day health care is care and services provided in a residential health care facility or approved extension site under the medical direction of a physician to a person who is functionally impaired, not homebound, and who requires certain preventive, diagnostic, therapeutic, rehabilitative or palliative items or services. Adult day health care includes the following services: medical, nursing, food and nutrition, social services, rehabilitation therapy, leisure time activities which are a planned program of diverse meaningful activities, dental, pharmaceutical, and other ancillary services.

Applicant shall mean an individual who has expressed a desire to pursue enrollment in a managed long term care demonstration.

Audiology/hearing aids: Audiology services include audiometric examination or testing, hearing aid evaluation, conformity evaluation and hearing aid prescription or recommendations if indicated. Hearing aid services include selecting, fitting and dispensing of hearing aids, hearing aid checks following dispensing and hearing aid repairs. Products include hearing aids, earmolds, batteries, special fittings and replacement parts.

Benefit Package: shall mean those medical and health-related services as defined in 42 CFR Section 460.92. They are also known as the Benefit Package services or Covered Services.

Capitation Rate shall mean the fixed monthly amount that the Contractor receives for an Enrollee to provide that Enrollee with the Benefit Package.

Conversion Therapy means any practice by a mental health professional that seeks to change an individual's sexual orientation or gender identity, including efforts to change behaviors, gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex.

Court-Ordered Services means those services that the Contractor is required to provide to Enrollees pursuant to orders of courts of competent jurisdiction, provided however, that such ordered services are within the Contractor's service package pursuant to 42 CFR Part 460.92, and are reimbursable under Title XVIII or Title XIX of the Social Security Act.

Community Based Long Term Care Services (CBLTCS) means health care and supportive services provided to individuals of all ages with functional limitations or chronic illnesses who require assistance with routine daily activities such as bathing, dressing, preparing meals, and administering medications. CBLTCS is comprised of services such as Home Health Services, Private Duty Nursing, Consumer Directed Personal Assistance Services, Adult Day Health Care Program, Personal Care Services.

Dentistry includes but shall not be limited to preventive, prophylactic and other dental care, services and supplies, routine exams, prophylaxis, oral surgery, and dental prosthetic and orthotic appliances required to alleviate a serious health condition including one which affects employability.

Durable Medical Equipment (DME), includes medical/surgical supplies, prosthetics and orthotics, and orthopedic footwear, enteral and parenteral formula and hearing aid batteries. Durable medical equipment are devices and equipment, other than prosthetic or orthotic appliances and devices, which have been ordered by a practitioner in the treatment of a specific medical condition and which have the following characteristics:

- can withstand repeated use for a protracted period of time,
- are primarily and customarily used for medical purposes,
- are generally not useful in the absence of an illness or injury; and
- are not usually fitted, designed or fashioned for a particular individual's use.
Where equipment is intended for use by only one patient, it may be either custom-made or customized.

Medical/surgical supplies are items for medical use other than drugs, prosthetic or orthotic appliances and devices, durable medical equipment or orthopedic footwear which treat a specific medical condition and which are usually consumable, non-reusable, disposable, for a specific purpose and generally have no salvageable value.

Prosthetic appliances and devices are appliances and devices, which replace any missing part of the body.

Orthotic appliances and devices are appliances and devices used to support a weak or deformed body member or to restrict or eliminate motion in a diseased or injured part of the body.

Orthopedic footwear are shoes, shoe modifications or shoe additions which are used to correct, accommodate or prevent a physical deformity or range of motion malfunction in a diseased or injured part of the ankle or foot; to support a weak or deformed structure of the ankle or foot or to form an integral part of a brace. Medicaid covered prescription footwear is limited to treatment of diabetics, or when the shoe is part of a leg brace (orthotic) or if there are foot complications in children under age 21.

Medicaid covered compression and support stockings are limited to coverage only for pregnancy or treatment for venous stasis ulcers.

Medicaid coverage of enteral formula and nutritional supplements is limited to individuals who cannot obtain nutrition through any other means, and to the following three conditions: individuals who are fed via nasogastric, jejunostomy, or gastrostomy tube feeding; individuals with inborn metabolic disorders; and Children up to 21 years of age who require liquid oral enteral nutritional formula when there is a documented diagnostic condition where caloric and dietary nutrients from food cannot be absorbed or metabolized. Coverage of certain inherited disease of amino acid and organic acid metabolism shall include modified solid food products that are low protein or which contain modified protein.

Effective Date of Disenrollment shall mean the date on which an Enrollee may no longer receive services from the Contractor, as determined using the process articulated in Appendix S of the

PACE Program Agreement.

Effective Date of Enrollment shall mean the date on which an Enrollee may receive services from the Contractor, as determined using the process articulated in Appendix E of the PACE Program Agreement.

Enrollee shall mean a person enrolled in the plan who is entitled to covered services in accordance with the provisions of the Agreement from the effective date of his/her enrollment until the effective date of his/her disenrollment. An Enrollee is also known as a participant.

Fiscal Agent shall mean the entity that processes or pays vendor claims on behalf of the Medicaid state agency pursuant to an agreement between the entity and such agency.

Health Commerce System (HCS) means a closed communication network dedicated to secure data exchange and distribution of health related information between various health facility providers and the Department. HCS functions include: collection of Complaint and Disenrollment information; collection of financial reports; collection and reporting of managed care provider networks systems (PNS); and the reporting of encounter data systems (MEDS III) or its successor system.

Home care includes the following services which are of a preventive, therapeutic rehabilitative, health guidance and/or supportive nature: nursing services, home health aide services, nutritional services, social work services, physical therapy, occupational therapy and speech/language pathology.

Home health aide means a person who carries out health care tasks under the supervision of a registered nurse or licensed therapist and who may also provide assistance with personal hygiene, housekeeping and other related supportive tasks to an Enrollee with health care needs in his home. Qualifications of home health aides are defined in Section 700.2(b)(9) of Title 10 NYCRR.

Inpatient hospital services are those items and services, provided under the direction of a physician, physician's assistant, nurse practitioner, or dentist, ordinarily furnished by the hospital for the care and treatment of inpatients. Inpatient hospital services include care, treatment, maintenance and nursing services as may be required on an inpatient hospital basis. Among other services, inpatient hospital service encompass a full range of necessary diagnostic and therapeutic care including medical, surgical, nursing, radiological and rehabilitative services.

Laboratory services include medically necessary tests and procedures ordered by a qualified medical professional and listed in the Medicaid fee schedule for laboratory services. Physicians providing laboratory testing may perform specific laboratory testing procedures identified in the Physician's eMedNY Provider Manual.

Managed Long Term Care Quality Incentive means a monetary incentive in the form of an add-on to managed long term care capitation payment rates that is awarded to MLTCs with superior performance in relation to a predetermined set of measures which may include quality of care, consumer satisfaction and compliance measures.

Meals are Home-delivered and congregate meals provided in accordance with each individual Enrollee's plan of care.

Money Follows the Person (MFP) means a demonstration that is part of Federal and State initiatives designed to rebalance long term care services, and promote consumer choice. As New York State continues to shift the focus of its long term care systems away from institutional care and towards integrated home and community-based care, support from the MFP program becomes valuable to all Managed Care Organizations (MCOs). MFP is designed to streamline the process of deinstitutionalization for vulnerable populations. Under the name Open Doors, the MFP program funds Transition Specialists and Peer Support to assist these individuals to transition out of institutions such as nursing homes and intermediate care facilities, and into qualifying community settings. A qualified setting may be a house, an apartment, or a group home (with a maximum of four unrelated people).

LDSS shall mean Local Department of Social Services or the Human Resources Administration of the City of New York.

NAMI shall mean the amount of net available monthly income determined by the Department that a nursing home resident must pay monthly to the nursing home (or to the Contractor if stipulated in the Subcontract agreement) in accordance with the requirements of the medical assistance program.

New York State of Health (NYSoH) means an office located within the New York State Department of Health that functions as the state's official health insurance marketplace. The NYSoH was established in accordance with the Patient Protection and Affordable Care Act of 2010. NYSoH provides a web portal through which individuals may apply for and enroll in Medicaid and other government sponsored health insurance, or purchase standardized health insurance that is eligible for federal subsidies.

Nurse practitioner services mean services provided under a practice agreement and practice protocol with a collaborating physician (agreement and protocol available to the Department during Medicaid audits) which meet the definitions for nurse practitioner services in the eMedNY Provider Manual, generally services considered to be primary care.

Nursing services include intermittent, part-time and continuous nursing services provided in accordance with an ordering physician's treatment plan as outlined in the physician's recommendation. Nursing services must be provided by RNs and LPNs in accordance with the Nurse Practice Act. Nursing services include care rendered directly to the individual and instructions to his family or caretaker in the procedures necessary for the patient's treatment or maintenance.

Nursing home care is care provided to Enrollees by a licensed facility as specified in Chapter V of 10 NYCRR.

Nutrition means the assessment of nutritional needs and food patterns, or the planning for the provision of foods and drink appropriate for the individual's physical and medical needs and environmental conditions, or the provision of nutrition education and counseling to meet normal and therapeutic needs. In addition, these services may include the assessment of nutritional status and food preferences, planning for provision of appropriate dietary intake within the patient's home environment and cultural considerations, nutritional education regarding therapeutic diets as part of the treatment milieu, development of a nutritional treatment plan, regular evaluation and revision of nutritional plans, provision of in-service education to health agency staff as well as

consultation on a specific dietary problems of patients and nutrition teaching to patients and families. These services must be provided by a qualified nutritionist as defined in Section 700.2(b)(5) of 10 NYCRR.

NYS Value Based Payment (VBP) Roadmap means a document that is updated annually by SDOH and approved by CMS to ensure that best practices and lessons learned throughout implementation of Value Based Payment into Medicaid Managed Long Term Care are leveraged and incorporated into the State's overall vision. The NYS VBP Roadmap is published on the SDOH website: www.health.ny.gov.

Occupational therapy: Rehabilitation services provided by a licensed and registered occupational therapist for the purpose of maximum reduction of physical or mental disability and restoration of the Enrollee to his or her best functional level. Medicaid coverage of occupational therapy provided in a setting other than a home is limited to 20 visits per calendar year, except for children under age 21 and the developmentally disabled. A MLTC plan may authorize additional visits.

Optometry includes the services of an optometrist and an ophthalmic dispenser, and includes eyeglasses, medical necessary contact lenses and polycarbonate lenses, artificial eyes (stock or custom made) and low vision aids. The optometrist may perform an eye exam to detect visual defects and eye disease as necessary or as required by the Enrollee's condition. Examinations which include refraction are limited to every two years unless otherwise justified as medically necessary.

If the Contractor does not provide upgraded eyeglass frames or additional features (such as scratch coating, progressive lenses or photo-gray lenses) as part of its covered vision benefit, the Contractor cannot apply the cost of its covered eyeglass benefit to the total cost of the eyeglasses the Enrollee wants and bill only the difference to the Enrollee. For example, if the Contractor covers only standard bifocal lenses and the Enrollee wants no-line bifocal lenses, the Enrollee must choose between taking the standard bifocal or paying the full price of the no-line bifocal lenses (not just the difference between the cost of the bifocal lenses and the no-line lenses). However, the Enrollee may pay for upgraded lenses as a private customer and have the Contractor pay for the frames or pay for upgraded frames as a private customer and have the Contractor pay for the lenses. The Enrollee must be informed of this fact by the vision care provider at the time that the glasses are ordered.

An ophthalmic dispenser fills the prescription of an optometrist or ophthalmologist and supplies eyeglasses or other vision aids upon the order of qualified practitioner. Coverage includes the replacement of lost or destroyed eyeglasses. The replacement of a complete pair of eyeglasses should duplicate the original prescription and frames. Coverage also includes the repair or replacement of parts in situations where the damage is the result of causes other than defective workmanship. Replacement parts should duplicate the original prescription and frames. Repairs to and replacement of frames and/or lenses must be rendered as needed. Eyeglasses do not require changing more frequently than every two years unless medically indicated, such as a change in correction greater than ½ diopter, or unless the glasses are lost, damaged, or destroyed.

If the Contractor does not provide upgraded eyeglass frames or additional features (such as scratch coating, progressive lenses or photo-gray lenses) as part of its covered vision benefit, the Contractor cannot apply the cost of its covered eyeglass benefit to the total cost of the eyeglasses the Enrollee wants and bill only the difference to the Enrollee. For example, if the Contractor covers only standard bifocal lenses and the Enrollee wants no-line bifocal lenses, the Enrollee must

choose between taking the standard bifocal or paying the full price of the no-line bifocal lenses (not just the difference between the cost of the bifocal lenses and the no-line lenses). However, the Enrollee may pay for upgraded lenses as a private customer and have the Contractor pay for the frames or pay for upgraded frames as a private customer and have the Contractor pay for the lenses. The Enrollee must be informed of this fact by the vision care provider at the time that the glasses are ordered.

Outpatient hospital services are services which are provided by a hospital division or department primarily engaged in providing services for ambulatory patients, by or under the supervision of a physician, for the prevention, diagnosis or treatment of human disease, pain, injury, deformity or physical condition.

Participating Provider means a provider of care and/or services that has a Provider Agreement with the Contractor.

Party shall mean either the Department or the Contractor.

Personal care means some or total assistance with such activities as personal hygiene, dressing and feeding, and nutritional and environmental support function tasks. Personal care must be medically necessary, ordered by the Enrollee's physician and provided by a qualified person as defined in Section 700.2(b)(14) 10 NYCRR, in accordance with a plan of care.

Personal Emergency Response System (PERS): PERS is an electronic device which enables certain high-risk patients to secure help in the event of a physical, emotional or environmental emergency. A variety of electronic alert systems now exist which employ different signaling devices. Such systems are usually connected to a patient's phone and signal a response center once a "help" button is activated. In the event of an emergency, the signal is received and appropriately acted on by a response center.

Physical therapy: Rehabilitation services provided by a licensed and registered physical therapist for the purpose of maximum reduction of physical or mental disability and restoration of the Enrollee to his or her best functional level. Medicaid coverage of physical therapy provided in a setting other than a home is limited to 20 visits per calendar year, except for children under age 21 and the developmentally disabled. A MLTC plan may authorize additional visits.

Podiatry: Podiatry means services by a podiatrist which must include routine foot care when the Enrollee's physical condition poses a hazard due to the presence of localized illness, injury or symptoms involving the foot, or when they are performed as necessary and integral part of medical care such as the diagnosis and treatment of diabetes, ulcers, and infections. Routine hygienic care of the feet, the treatment of corns and calluses, the trimming of nails, and other hygienic care such as cleaning or soaking feet, is not covered in the absence of pathological condition.

Private duty nursing services are continuous and skilled nursing care provided in an Enrollee's home by properly licensed registered professional or licensed practical nurses.

Provider Contract: shall mean a written contract with the Contractor pursuant to which a person or entity provides certain services or items the Contractor deems necessary or advisable to the operation of the plan.

Provider: shall mean a person or entity with whom the Contractor has entered into a written

Provider Contract.

Radiology and radioisotope services include medically necessary services provided by qualified practitioners in the provision of diagnostic radiology, diagnostic ultrasound, nuclear medicine, radiation oncology, and magnetic resonance imaging (MRI). These services are performed upon the order of a qualified practitioner.

Respiratory therapy means the performance of preventive, maintenance and rehabilitative airway-related techniques and procedures including the application of medical gases, humidity, and aerosols, intermittent positive pressure, continuous artificial ventilation, the administration of drugs through inhalation and related airway management, patient care, instruction of patients and provision of consultation to other health personnel. These services must be provided by a qualified respiratory therapist as defined in Section 700.2(b)(33) 10 NYCRR.

Roster shall mean the enrollment list generated on a monthly basis by SDOH by which LDSS and Contractor are informed of specifically which recipients the Contractor will be serving for the coming month, subject to any revisions communicated in writing or electronically by SDOH or LDSS.

Social and environmental supports are services and items that support the medical needs of the Enrollees and are included in an Enrollee's plan of care. These services and items include but are not limited to the following: home maintenance tasks, homemaker/chore services, housing improvement, and respite care.

Social day care is a structured, comprehensive program which provides functionally impaired individuals with socialization, supervision and monitoring, personal care, and nutrition in a protective setting during any part of the day, but for less than a 24-hour period. Additional services may include and are not limited to maintenance and enhancement of daily living skills, transportation, caregiver assistance, and case coordination and assistance.

Social services are information, referral, and assistance with obtaining or maintaining benefits which include financial assistance, medical assistance, food stamps, or other support programs provided by the LDSS, Social Security Administration, and other sources. Social services also involve providing supports and addressing problems in an Enrollee's living environment and daily activities to assist the Enrollee to remain in the community.

Speech-language pathology: A licensed and registered speech-language pathologist provides rehabilitation services for the purpose of maximum reduction of physical or mental disability and restoration of the Enrollee to his or her best functional level. Medicaid coverage of speech therapy provided in a setting other than a home is limited to 20 visits per calendar year, except for children under age 21 and the developmentally disabled. A MLTC plan may authorize additional visits

Spenddown shall mean the amount of medical expenses the Department determines a "medically needy" individual must incur in any period in order to be eligible for medical assistance (as currently described in 18 NYCRR 360-4.8). Spenddown amounts are also referred to as surplus.

Third Party Health Insurance (TPHI) shall mean comprehensive health care coverage or insurance (including Medicare and/or private MCO coverage) that does not fall under one of the following categories:

- a) accident-only coverage or disability income insurance;
- b) coverage issued as a supplement to liability insurance;
- c) liability insurance, including auto insurance;
- d) workers compensation or similar insurance;
- e) automobile medical payment insurance;
- f) credit-only insurance;
- g) coverage for on-site medical clinics;
- h) dental-only, vision-only, or long-term care insurance;
- i) specified disease coverage;
- j) hospital indemnity or other fixed dollar indemnity coverage; or
- k) prescription-only coverage.

Transportation shall mean transport by ambulance, ambulette, taxi or livery service or public transportation at the appropriate level for the Enrollee's condition for the Enrollee to obtain necessary medical care and services reimbursed under the New York State Plan for Medical Assistance or the Medicare Program. The Contractor is required to use only approved Medicaid ambulette vendors to provide ambulette transportation services to Enrollees.

Value Based Payment (VBP) means a strategy that is used by purchasers to promote quality and value of healthcare services. The goal if any VBP program is to shift from pure volume-based payment, as exemplified by fee-for-service payments to payments that are more closely related to both quality and cost outcomes.

VBP Innovator Program means a program that is for qualifying providers that are supporting the total cost of care for both VBP subpopulations and the general population of their attributed members under an advanced VBP Level 2 or a VBP Level 3 arrangement. SDOH is responsible for identifying providers that qualify to participate in this program.

APPENDIX G

CONFLICT FREE EVALUATION AND ENROLLMENT CENTER (CFEEC)

- I. Where the Contractor operates in a county designated for mandatory enrollment into any Managed Long Term Care (MLTC) plan, all initial eligibility determinations for MLTC plans will be made by the Conflict Free Evaluation and Enrollment Center (CFEEC), or another entity designated by the Department. CFEEC evaluations are required for all MLTC products, including PACE. All persons seeking information about the Contractor's PACE plan, or seeking enrollment into such product(s), should be forwarded to the CFEEC in accordance with Departmental rules and guidance. If and when the CFEEC determines a persons to be eligible for a MLTC plan, the CFEEC will forward said person to the MLTC plan of his or her choice. After receiving a referral from the CFEEC, Contractor remains responsible for conducting all assessments required prior to enrollment, as indicated in 42 CFR §460.104.
- II. Counties designated for utilization of the CFEEC will be implemented in a manner determined by the Department. Contractor will comply with the implementation of the CFEEC based on guidance issued by the Department.
- III. Effective January 1, 2015, the Contractor must remove all contact information to the Contractor's eligibility assessment staff, agents, subcontractors, and any entities that perform eligibility assessments on behalf of the Contractor, from all PACE plan marketing materials and member handbooks.
 - a. Upon submission to the Department for approval, the Contractor may seek a waiver of this provision from the Department. In doing so, the Contractor should provide the reason why the contact information should remain on the material in question. For example, the Contractor might utilize a single, general purpose phone number to handle all or most Enrollee or Potential Enrollee questions or concerns, in which case the Contractor should indicate what steps they have taken to capture and forward persons seeking enrollment/eligibility determinations to the CFEEC. The Department reserves the sole right to determine whether to waive this provision.
- IV. Effective January 1, 2015, the Contractor must provide the contact information for the CFEEC, or other entity designated by the Department, on all plan materials that can reasonably be interpreted as intended to market to Potential Enrollees.
- V. To the extent that any provisions in this Agreement are in conflict with the provisions of this appendix, the provisions of this appendix prevail.

APPENDIX H
APPROVED CAPITATION RATES

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APPENDIX X-2

MODIFICATION AGREEMENT FORM

APPENDIX X-2

Agency Code _____ Contract No _____
Period _____ Funding Amount for Period _____

This is an AGREEMENT between THE STATE OF NEW YORK, acting by and through
The New York State Department of Health, having its principal office at One Commerce Plaza, 99 Washington Avenue,
1620, Albany, NY 12210, (hereinafter referred to as the STATE), and _____, (hereinafter
referred to as the CONTRACTOR), to modify Contract Number ___ as set forth below .

All other provisions of said AGREEMENT shall remain in full force and effect.

IN WITNESS WHEREOF, the parties hereto have executed or approved this AGREEMENT as of the dates appearing
under their signatures.

CONTRACTOR SIGNATURE

STATE AGENCY SIGNATURE

By: _____

By: _____

Printed Name _____

Printed Name _____

Title: _____

Title: _____

Date: _____

Date: _____

State Agency Certification:
In addition to the acceptance of this contract, I also certify
that original copies of this signature page will be attached
to all other exact copies of this contract.

STATE OF NEW YORK)
) SS.:
County of _____)

On the _____ day of _____ in the year _____, before me, the undersigned,
personally appeared _____, personally known to me or proved to me on the basis
of satisfactory evidence to be the individual(s) whose names(s) is (are) subscribed to the within instrument and
acknowledged to me that he/she/they executed the same in his/her/their/ capacity(ies), and that by his/her/their
signature(s) on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed
the instrument.

Notary

Approved:

Approved:

ATTORNEY GENERAL

Thomas P. DiNapoli
STATE COMPTROLLER

Title: _____

Title: _____

Date: _____

Date: _____