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Overview

Programs of All-Inclusive Care for the Elderly (PACE) around the country are requesting waivers from the Centers for Medicare & Medicaid Services (CMS) to adapt the PACE Model of Care as they seek to better serve individuals who need the comprehensive, coordinated care that PACE organizations provide. Many are working with community-based primary care physicians (CBPs) to enable PACE enrollees to maintain established relationships with their physicians and participate in PACE. For a number of PACE organizations, particularly those in rural communities, working with CBPs allows them to reach more people, especially over great distances.

This issue brief examines the process by which CMS provides CBP waivers and the criteria applied in their review. This brief also provides an overview of the extent to which PACE organizations currently have relationships with CBPs to provide care to PACE participants and outlines their experiences to date. A sample request letter and contract for use by PACE organizations are included.

PACE Regulatory Requirements Related to Primary Care

Enrollment in PACE requires that participants consent to receive care from the PACE organization staff and its network of providers. PACE Regulations [Section 460.102(a)(1)] further require that each participant’s care be coordinated by an interdisciplinary team (IDT) based at a PACE center. Members of the IDT are required to serve primarily PACE participants [Section 460.102(d)(3)].

As a result, PACE regulatory requirements may limit enrollment in a number of ways:

- Potential participants, who are otherwise interested in enrolling in PACE, may want to have greater flexibility in choosing their primary care providers.
- PACE organizations may struggle to build sufficient primary care capacity to meet the needs of a growing number of participants.
- Access to PACE across large service areas may be insufficient if the delivery of primary care is restricted to one or more centralized PACE center locations.

In an effort to address these limitations and help PACE organizations expand access to care, Sections 902 and 903 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) (PL 106-554) provide CMS flexibility to grant waiver requests to PACE organizations to develop contracts with CBPs. The organizations must apply for waivers to relieve the following regulatory requirements:

- The primary care physician must either be a staff or contracted physician based at a PACE center, and
- The primary care physician, as a member of the PACE IDT, must primarily serve PACE participants.
BIPA Waivers

The Benefits Improvement and Protection Act authorizes CMS to waive certain PACE regulatory requirements. Section 902 grants the CMS secretary the authority to grandfather operational modifications implemented by the initial 15 PACE demonstration programs. Specifically, the provision allows the PACE demonstrations to continue using program modifications, including the use of CBPs, that were in effect on July 1, 2000. PACE organizations using CBPs under BIPA 902 authority have “general organizational-wide waivers” that are permanent and do not need to be reviewed annually by CMS.

Other PACE organizations that utilized CBPs as of July 1, 2000, are able to use CBPs as a result of Section 903 of BIPA. Section 903 grants CMS flexibility in exercising waiver authority provided under Sections 1894(f)(2)(B) and 1934(f)(2)(B) of the Social Security Act. Moreover, Section 903 allows for specific modifications or waivers of certain regulatory provisions to meet the needs of PACE organizations, allowing for them to utilize CBPs with the approval of CMS. PACE organizations that receive CBP waivers under Section 903 obtain “conditional organization-wide waivers,” which require regular CMS assessments regarding the quality of care provided through the CBPs. In 2002 CMS established a process to submit and approve waiver requests, many of which are for CBPs.

Current Use of CBP Waivers

As of January 2015, 17 of the 108 PACE organizations had CBP waivers, representing nearly 16 percent of all PACE organizations nationwide. These organizations operate across 12 of the 32 states with PACE. More than a third of PACE organizations with CBP waivers are located in New York. The other 11 states have one PACE organization with a CBP waiver. (See Table 1.)

Rural programs comprise a fairly significant share of PACE organizations with CBP waivers. Although only about 15 percent of PACE organizations are rural, six of the 17 organizations with a CBP waiver are rural programs, representing 35 percent of all PACE organizations with CBP waivers. (See Figure 1.) On average, the six rural programs have been operating for approximately seven years with a census of 149 participants, while the 11 urban programs are nearly six times larger, with an average census of 842. In general, the urban programs are more mature. They have been operating for 11 years, an average of four more years than the rural programs.

Generally, PACE organizations with CBP waivers are older and have larger censuses than PACE organizations overall. The 108 PACE organizations have an average census of 334 and have been operating for nine years. The 17 programs with CBP waivers have an average census of 597 and have been operating for 15 years on average.
Table 1: Number of PACE Organizations with CBP Waivers

<table>
<thead>
<tr>
<th>State</th>
<th>PACE Organizations with CBP Waivers</th>
<th>PACE Organizations in State</th>
<th>Have Rural Program with CBP Waivers</th>
</tr>
</thead>
<tbody>
<tr>
<td>California</td>
<td>1</td>
<td>10</td>
<td>No</td>
</tr>
<tr>
<td>Colorado</td>
<td>1</td>
<td>3</td>
<td>Yes</td>
</tr>
<tr>
<td>Florida</td>
<td>1</td>
<td>4</td>
<td>No</td>
</tr>
<tr>
<td>Kansas</td>
<td>1</td>
<td>2</td>
<td>Yes</td>
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<tr>
<td>Michigan</td>
<td>1</td>
<td>6</td>
<td>No</td>
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<tr>
<td>New York</td>
<td>6</td>
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<td>Yes</td>
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<td>North Dakota</td>
<td>1</td>
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<td>Oregon</td>
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<td>1</td>
<td>No</td>
</tr>
<tr>
<td>Pennsylvania</td>
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<td>18</td>
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</tr>
<tr>
<td>Rhode Island</td>
<td>1</td>
<td>1</td>
<td>No</td>
</tr>
<tr>
<td>Virginia</td>
<td>1</td>
<td>7</td>
<td>Yes</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>1</td>
<td>1</td>
<td>No</td>
</tr>
</tbody>
</table>
Figure 1: Distribution of CBP Waivers

The National PACE Association (NPA) received information on 15 of the 17 CBP waiver approvals. A review of the information found that 14 PACE organizations have conditional organization-wide waivers, which require annual reviews by CMS to ensure quality. Only one organization has a general organizational-wide waiver, which is a BIPA 902 permanent waiver as a result of using the CBPs during the PACE demonstration period.

Experience of PACE Organizations Using CBPs

For 13 of the 15 waivers NPA has information on, PACE organizations are allowed an average of 12 CBPs, with a range of four to 25. Two organizations – an urban program in New York and a rural program in Colorado – do not have a cap for the number of CBPs they contract with. The New York PACE organization has a 902 non-conditional BIPA waiver, and the Colorado program is based in a medically underserved area with a shortage of health professionals.

Generally, CMS recognizes the challenges of working in rural communities. Rural PACE organizations typically serve much larger service areas, have smaller censuses, and face staffing challenges. Consequently, CMS tends to be more open to allowing CBP waivers for rural programs. On average, urban programs are limited to nine CBPs, compared to 13 CBPs for rural programs.

Three rural PACE organizations with CBP waivers have specific guidelines outlined in their approval letters from CMS:

- the specific facilities and agencies the organization may contract with for CBPs;
- the number of participants assigned to one or more PACE centers for whom CBPs may be utilized to provide primary care; and
- the number of CBPs for specific areas in the catchment area of the organization.
These guidelines were written into the waiver approval letters sent to the PACE organizations that had requested specific facilities, centers or service areas. Other waiver approvals likely lacked such specificity because the request letters submitted by the PACE organization were not as limiting.

In 2006 CMS contracted with Mathematica Policy Research, Inc., to review the rationale behind why PACE organizations use CBPs, how they work with them, and the ways in which communication occurs between the organizations and the physicians. Mathematica evaluated two PACE organizations in California and New York. The organization in New York felt that firmly established relationships with providers were important and did not want to break them. The California-based PACE organization sought to connect with new ethnic communities, working with CBPs to serve previously underserved populations. Neither organization directly recruited CBPs. They worked to recruit prospective participants and then developed working relationships with their physicians.

To facilitate effective communication with the CBPs, the organizations scheduled the medical visits for their participants. As a result, the PACE organizations knew when the visits took place and could follow up with the CBPs to determine if there were any changes to their care plans.

The CBPs had to learn how to work effectively as a member of the PACE IDT, the evaluation noted. Although some CBPs opted to discontinue their relationship with PACE, both organizations found it helpful to work with CBPs to serve more participants. Despite some challenges, both continue to use CBPs.

The CMS evaluation did not review quality or cost information. In 2013 NPA engaged in an analysis to review various PACE model variations, including the use of CBPs, to determine their impact on quality of care and operational costs. The analysis compared data from the 13 organizations with CBP waivers to data from organizations that were not using the waivers. In general, NPA found no marked differences between the two groups in terms of 30-day hospital readmission rates, member disenrollment rates, or per-member per-month primary care costs.

**CMS Requirements for PACE Organizations Using CBPs**

Although PACE organizations and their participants can benefit from the use of CBPs, CMS has expressed concerns about how those physicians are integrated into the PACE Model of Care. In the 2006 report by Mathematica, CMS indicated concern that CBPs “who may not embrace the PACE philosophy or may not want to work with the program IDT may compromise the quality of care that a PACE program provides.” Therefore, it is imperative for PACE organizations to ensure that CBPs fully understand and accept the PACE philosophy of care and recognize their role in providing care.

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1 How Integrated Care Programs Use Community-Based Primary Care Physicians
When approving CBP waivers, CMS asserts that the physicians will have the same responsibilities as PACE primary care providers. In particular, CBPs are expected to do the following:

- regularly participate in IDT meetings, either in person or via conference call, when CBP participants are discussed;
- conduct participant assessments;
- be involved in the development of participant’s plan of care;
- participate in quality assessment and performance improvement activities; and
- have a comprehensive understanding of the PACE Model of Care and a commitment to its philosophy as well as the PACE approach to integrative care.

Although CBPs are expected to be accountable for the care they provide to participants, the PACE organization that works with them ultimately is responsible for how the care is provided and for ensuring that adequate communication occurs between the IDT and the CBP. In all but one of the waiver allowances, CMS affirms the following:

- PACE medical directors and nurse practitioners (NPs), if applicable, are expected to facilitate collaboration and communication between the IDT and CBP. Individuals in both roles at each PACE organization are expected to be actively involved in the care and treatment of each participant who receives care from a CBP.
- NPs and registered nurses will enable timely and complete transfers of medical records between the CBP office and the PACE organization.
- PACE organizations will provide CBPs with a PACE program orientation and key office staff with an overview of the model.
- The PACE medical director will retain the overall responsibility for the delivery of participant care, clinical outcomes, and implementation of the quality assessment and performance improvement program.

Finally, PACE organizations with a CBP waiver must notify CMS of any intent to expand the number and use of CBPs and to receive prior authorization before implementation. CMS did not specifically cite these stipulations in one waiver authorization letter from 2014, but its decision not to include them likely was based on the fact that the PACE organization addressed each of the key areas in the initial waiver request letter. Based on that letter, it is clear the organization accounted for everything that CMS required and proactively addressed any potential concerns.

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2 The PACE organization had addressed each CMS requirement in its waiver request letter.
Two urban PACE organizations in New York have CBP waiver approval letters that contain stipulations for “evaluating the impact this approval [of a CBP waiver] will have on policies, procedures, marketing materials, and services to PACE participants.” CMS requires the PACE organizations to submit any updates to the state. Additionally, CMS expects to be notified of any leadership changes in the organizations. It is important to note that the aforementioned language was lacking in other waiver approval letters, including the four other programs in New York with CBP waivers.

CMS generally informs PACE organizations that it will monitor the arrangement and will reconsider its approval if the arrangement is not consistent with the requirements stipulated in the approval letter.

**CBP Waiver Request Letter**

PACE organizations must submit CBP waiver requests to their State Administering Agency (SAA). The state reviews the request and forwards it to CMS with any comments and concerns. CMS arrives at a determination within 90 days of receiving the waiver request.

Although CMS reviews requests on a case-by-case basis, a PACE organization most likely will receive a timely and positive review if it does the following:

- specifically identifies the request as a waiver request;
- identifies the regulatory section that it wants to have waived;
- provides the rationale behind the waiver request;
- lists the policies and procedures put in place to ensure participant care will not be comprised;
- indicates how communication will be facilitated between the CBP and IDT when discussing participants and sharing medical records;
- describes its approach to orient CBPs to PACE;
- indicates the location(s) where the CBP will provide care for the participant; and
- indicates whether the request was submitted previously as a BIPA 902 grandfathering request or if it is a new request under section 903 of BIPA.

PACE organizations should include all of the documentation listed in Appendix 1 as indicated in the April 21, 2015, CMS memo, which is also available on the Medicaid.gov website in the BIPA 903 Waiver Requests section.
CMS has requested additional information from PACE organizations for waiver reviews. When applying for CBP waivers, an organization should do the following:

- provide assurance that it is completely responsible for the participant receiving care from the CBP;
- detail the ways it will facilitate communication between its office and that of the CBP;
- discuss methods of sharing the PACE philosophy with CBPs and their key office staff; and
- emphasize the role the medical director and NPs will have.

**PACE organizations also should address the following questions:**

- What is their current census?
- How many centers do they have?
- Are there any alternative care settings?
- What is their current number of PACE physicians?
- Do the PACE staff physicians provide care at the PACE center?
- What is the role of the medical director (e.g., administrative oversight of clinicians vs. direct provision of care), specifically their responsibility for the CBP process and overall outcomes?
- Is the medical director based at the PACE center? (If not, describe in detail how the duties are fulfilled from an alternate location.)
- Do they have a full-time medical director?
- How is the medical director’s time allocated (e.g., a 50/50 split between administrative and clinical oversight and providing direct care)?
- What is the process by which the medical director will provide oversight of CBPs?
- What are the prospective sources of CBPs? For example, is the organization limited to a handful of local practices?
- Can you describe the practices and provide a little more information about the specific physicians your organization would like to contract with? What is the estimated number of physicians your organization would contract with?
- Where will the CBP services be delivered (e.g., at the CBP office, in the PACE center)?
- How will you determine whether a participant will see the CBPs at the PACE center or at the CBP office?
If a participant will visit the CBP office, how will the individual get there?

For visits taking place at the CBP office, will the organization provide a staff escort to accompany the participant? If so, what will be the role and title of the escort?

How will the CBP duties be carried out as described in 460.102(c)-460.102(e) (e.g. physician and IDT duties), 460.104 (e.g., assessments, reassessments, care planning), and participation with quality assessment and performance improvement activities under the direction of the medical director?

Will CBPs participate in IDT meetings discussing their patients in person or via teleconferencing?

What is the process for sharing medical record information in a timely manner between the CBP and the PACE center?

What is the process for CBPs to order and participants to receive their prescriptions?

If the CBP orders a stat prescription to be picked up by a participant and taken that day and no escort is present, what assurance is there that the patient will receive the prescription promptly?

What is the role of the CBP in care during inpatient hospitalization and nursing home placement (CBP vs. PACE staff physician involvement)?

What are the on-call procedures for physicians (staff vs. CBPs)? Would a call be taken by the CBP or the PACE staff physician? How would updates from on-call care be communicated to the IDT?

What information is included in the CBP contract? (Provide a draft copy.)

What is the orientation and training process for CBPs that will facilitate compliance with §460.70 and §460.71?

What training is provided to the key staff at the CBP office to ensure they have an understanding of the PACE Model of Care?

Does your organization use telemedicine? (Provide a description.)

Does your organization use NPs? What is their role in conjunction with the proposed CBP model?
Additional Recommendations

NPA recommends that PACE organizations emphasize the following information when seeking CBP waivers:

- the projected census growth relative to current staffing resources for primary care services;
- the location in medically underserved areas (MUAs) and medical shortage areas;
- the ratio of PACE physicians to participants;
- how the lack of CBPs has impacted voluntary disenrollment rates; and
- how the lack of CBPs has impacted new enrollment and program growth.

Incorporating CBPs into PACE

For most PACE organizations with CBP waivers, the organization initiates the conversation with the CBP, usually as a result of one or more participants wanting to enroll in PACE but expressing hesitation in giving up their primary care provider. Dana Collins, director at AllCARE for Seniors, in Cedar Bluff, VA, indicates that occasionally a community physician has reached out to them, but it is a rare occurrence. More often, the PACE organization contacts the potential CBP to discuss developing a formal relationship to provide primary care for participants. Regardless of who initiates the conversation, PACE organizations indicate that accommodating participants’ longstanding relationships with their providers by incorporating CBPs often enhances impressions of PACE. Additionally, it may facilitate word-of-mouth marketing by participants as they talk about their care with their friends and family.

Before finalizing which provider to contract, it’s imperative to review background information on the physician. Generally, PACE organizations should consider the following:

- checking the physician’s license to ensure the individual is in good standing with Medicare and Medicaid,
- ensuring that the physician has at least one year of experience working in the field of geriatrics, and
- assessing whether the physician has a positive reputation in the community.

A key aspect of working with CBPs requires educating and orienting them to the PACE organization and the PACE Model of Care. Typically, the conversation should begin with discussing the history of the model and the PACE philosophy. Review the provider manual to delve more deeply into how PACE operates. If they are amenable and interested, it is prudent to invite CBPs for a tour of the PACE site so they can obtain a better understanding of what the program looks like and how it works. The entire process, which also includes developing and finalizing a contract, may take about a month. Having the medical director closely involved in
the process is critical, according to Jamie Leibowitz, Regulatory Compliance specialist at ElderONE in Rochester, NY. She affirms that the orientation should include information on how the PACE organization functions, how to contact and coordinate with the IDT, and the expectations for both the CBP and the organization. Be sure to talk about any necessary aspects regarding documentation requirements, participation in IDT meetings for assigned participants, care planning responsibilities, after-hour calls, and participation in quality assessment and improvement initiatives.

ElderONE and AllCARE handle the transportation of participants to the CBP office. An AllCARE nurse travels with the participant if there is no caregiver or one is not available. The PACE organization also ensures that a nurse attends the visit if participants have a cognitive disability, such as dementia, and may not be able to adequately articulate their needs. Communication is vital in ensuring success with the CBP model of care and typically is facilitated by the NP at AllCARE.

Leibowitz recommends developing and sharing a set care planning schedule for the participants assigned to the CBP. This ensures that CBPs have a better idea about the expectations and how often they need to be involved in the planning process. Care planning meetings and other communication typically occur via conference call and occasionally via video through the use of a webcam. However, medical records usually are faxed to the PACE organization and then scanned into the system. It’s rare for a CBP to come on site beyond the initial PACE orientation.

At ElderONE CBPs receive a flat fee and bill for each office visit. The rate is based on the Medicare rate for an office visit. The payment arrangement should be described in the contract between the PACE organization and the CBP. Refer to Appendix III to view a sample contract. Regardless of how many CBPs a PACE organization works with, the medical director ultimately retains responsibility for the delivery of participant care and clinical outcomes.

**Staff Contact**

NPA will continue to work to support PACE organizations in applying for CBP waivers. For more information, contact Sam Kunjukunju.
## APPENDIX I: CMS WAIVER REQUEST CHECKLIST

**PACE Waiver Requests for Using Nurse Practitioner or Community-Based Primary Care Physician As Part of the IDT**

<table>
<thead>
<tr>
<th>Waiver Documentation to Be Provided (Examples in Italics)</th>
<th>Nurse Practitioner</th>
<th>Community-Based PCP Waiver</th>
</tr>
</thead>
<tbody>
<tr>
<td>PACE Organization Description</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>How many PACE centers?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current participant census for the PACE organization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alternative care settings, etc.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PACE Physician Job Description</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>NP-Specific:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Will the Primary Care Physician provide oversight and collaborate with the NP? Yes or No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If no, provide a description to show who will collaborate with and provide oversight to the NP.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CB PCP-Specific:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provide current number of PACE Physicians on staff at the PACE center. Are they full-time or part-time?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Waiver Documentation to Be Provided (Examples in Italics)</td>
<td>Nurse Practitioner</td>
<td>Community-Based PCP Waiver</td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td>---------------------</td>
<td>----------------------------</td>
</tr>
<tr>
<td>PACE Medical Director Job Description</td>
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<td>X</td>
</tr>
<tr>
<td>NP-Specific:</td>
<td></td>
<td></td>
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<tr>
<td>Will the Medical Director retain overall responsibility for:</td>
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<td></td>
</tr>
<tr>
<td>Delivery of participant care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical outcomes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oversight of the QAPI</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If no, provide description to show who will provide the responsibility and oversight.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CB PCP-Specific:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Will the Medical Director provide the administrative oversight and/or direct participant care? Yes or No. If no, provide description as to who will provide that oversight.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the Medical Director full-time, and is he/she employed by the PACE organization? Yes or No. If no, provide description of the percentage of time spent at alternate location.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the PACE organization have policies and procedures in place to provide oversight to potential CB PCPs as required by 42 CFR §§460.70 &amp; 460.71? Yes or No.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CB PCP Proposed Job Description</td>
<td>N/A</td>
<td>X</td>
</tr>
<tr>
<td>Provide a number of CB PCPs you are wanting to contract with and details on the location of their current practice.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provide number of how many beneficiaries are being projected to be seen by the CB PCPs.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Will CB PCPs provide services in the PACE center? Yes or No. If no, where will they provide services?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the PACE organization have policies and procedures in place when transporting beneficiaries not only to the PACE center but to the CB PCPs location? Yes or No.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NP Proposed Job Description</td>
<td>X</td>
<td>N/A</td>
</tr>
<tr>
<td>------------------------------</td>
<td>---</td>
<td>-----</td>
</tr>
<tr>
<td>Documents that will need to be included, but not limited to:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing License</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education Degree</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Board Certification</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evidence of one-year experience with frail elderly</td>
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</tr>
<tr>
<td>Evidence of meeting all of the PACE organization’s position-specific competencies prior to working independently</td>
<td></td>
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</tr>
<tr>
<td>Cleared for all communicable diseases prior to evidence of direct participant contact</td>
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<td></td>
</tr>
<tr>
<td>Proof immunizations are up to date prior to direct participant contact</td>
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<tr>
<td>Additional member to the IDT team</td>
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<tr>
<td>NP and PCP Collaborative Agreement</td>
<td>X</td>
<td>N/A</td>
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<tr>
<td>Does the PACE organization have a collaborative agreement between the NP and the PCP?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes or No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX II: SAMPLE REQUEST LETTER

PACE Organization of Rhode Island provided this letter as an example of requesting to work with CBPs.

PACE Organization of Rhode Island

New Request for BIPA 903 Waiver Use of Community-Based Physicians

I. Purpose

The PACE Organization of Rhode Island (PORI) is requesting a waiver to utilize Community-Based Physicians to conduct services that, as set forth in the PACE regulations, are currently assigned to the PACE primary care physician. This waiver request is a new request under section 903 of the BIPA and is being submitted for the following reasons:

- Increasing census and expanded geographic reach requiring more medical personnel.
- Difficulty recruiting primary care physicians specializing in geriatric care.
- Reluctance of potential participants to change Primary Care Physicians.

1. Distance and Access: In anticipation of a potential merger with Adult Day Services of Westerly, we are predicting an increase in census with both center-based and homebound clients. Therefore, we intend to expand clinic hours and onsite service to the Westerly location. Westerly is a relatively remote area of Rhode Island 45 minutes away from the Providence location, and residents frequently seek care and services in Connecticut. Engaging local physicians will increase the chances of residents using the local center for care, they will have a familiarity and trust in those local providers, and many are already patients of those physicians, making a transition into PACE more likely. PORI intends to open a northern Rhode Island site 40 minutes from the Providence site. The main hospital in this region of the state is currently in bankruptcy and has had two failed merger attempts over the past three years. The community health center is the primary health care provider in this community. PACE currently serves over 40 individuals from this area. Establishing a site will give these individuals a more convenient health care solution, and it will fill a gap for elders who cannot or prefer not to travel for their care. With the downsizing at the hospital, there is the opportunity for us to work with hospital-affiliated physicians who have capacity. This would benefit the local health care community, with PACE offering a solution to this threatened health care system for clients and providers.
2. Shortage of primary care physicians: With 1.3 million residents, Rhode Island is facing a shortage of primary care physicians similar to national trends. Many practices are merging into larger groups, and most are working toward achieving medical home status. With this move toward coordinated medical care, we believe we would be able to contract with a practice that shares the PACE philosophy of care. In addition, practices are recruiting new physicians from outside of the Rhode Island area. Building a practice immediately is difficult to achieve but financially necessary for the practice. Therefore, by contracting with a practice, we would be able to fill that temporary void of building a practice.

3. Reluctance to change: The Rhode Island health care landscape is not different from the rest of the country; but, given our size, practitioners know each other well. The No. 1 reason for an individual choosing not to sign onto PACE is a reluctance to change physicians. If PACE were to contract with the key physician practices whose focus is older adults, we would be able to provide continuity of primary care and add much-needed services for these individuals.

II. PACE Regulation

PORI is requesting that the following sections of the PACE Regulations be waived:

### § 460.102 INTERDISCIPLINARY TEAM.

(c) Primary care physician.

(1) Primary medical care must be furnished to a participant by a PACE primary care physician.

(2) Each primary care physician is responsible for the following:

(i) Managing a participant’s medical situations.

(ii) Overseeing a participant’s use of medical specialists and inpatient care.

(d) Responsibilities of the Interdisciplinary Team

(3) The members of the Interdisciplinary Team must serve primarily PACE participants.

### § 460.104 PARTICIPANT ASSESSMENT.

(a) Initial comprehensive assessment—

(1) Basic requirement. The interdisciplinary team must conduct an initial comprehensive assessment on each participant. The assessment must be completed promptly following enrollment.

(2) As part of the initial comprehensive assessment, each of the following members of the interdisciplinary team must evaluate the participant in person, at appropriate intervals, and develop a discipline-specific assessment of the participant’s health and social status:

(i) Primary care physician
(b) Development of plan of care. The interdisciplinary team must promptly consolidate discipline-specific assessments into a single plan of care for each participant through discussion in team meetings and consensus of the entire interdisciplinary team.

(c) Periodic reassessment—

(1) Semiannual reassessment. On at least a semiannual basis, or more often if a participant’s condition dictates, the following members of the interdisciplinary team must conduct an in-person reassessment:

(i) Primary care physician

III. PRACTICES

Personnel Requirements

A. All employees must present proof of licensure in Rhode Island. Licensure also may be verified on the RIDOH website.

B. Community Physicians will provide the organization with evidence of current certification by a national certifying body and proof of completion of an accredited educational program. Maintenance of Board Certification in Family Medicine or Internal Medicine and experience with the management of geriatric patients also is expected.

C. Members of the IDT and PACE staff that are required by regulation shall have at least one year of experience working with the frail elderly.

D. All employees of the organization must meet the following:

1. Medical clearance for communicable diseases prior to direct participant contact.

2. Up-to-date immunizations prior to direct participant contact.

3. Orientation to the PACE program and model of care.

4. Completion of position-specific competencies prior to working independently. (Attachment A)
Integration into the Interdisciplinary Team

Prior to seeing PACE patients, the Community-Based Primary Care Physician (CB PCP) will receive an extensive orientation curriculum and complete an initial training and competency checklist. The National PACE Association (NPA) Model Practice Guidelines will be reviewed with the CB PCP by the medical director. Key staff in the CB PCP’s office will be provided with an orientation to the PACE Model of Care.

The CB PCP will document in the PACE electronic medical record.

Coverage for sick visits, nursing home visits and hospitalizations will be coordinated by the CB PCP through the PACE Center to which the participant is assigned.

The CB PCP will participate in the IDT Care Plan Meeting, in person or by telephone conference call, when the participants assigned to the CB PCP are being discussed, developed, or modified.

The CB PCP will perform required initial and biannual assessments for participants assigned to them and in response to changes in participants’ health status.

The CB PCP will participate in Quality Improvement Initiatives as assigned by the Medical Director.

The CB PCP will participate in at least one of the weekly Health Center Divisional Meetings per month, in person or by conference call.

The CB PCP will have access to a designated PACE NP/MD staff for collaboration 24/7.

The CB PCP will maintain regular contact with the PACE practicing physicians, NPs, and other members of the interdisciplinary team to allow both parties to remain current on the treatment of participants.
### Initial Training and Competency Checklist: Physician

Employee Name __________________________  Date of Hire __________________________

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#### Department Overview
- Department Meetings
- All Staff Meetings
- In-Service Calendar
- Role in the Organization
- Job Description

#### Resources
- Policy Manual
- Procedure Manual

#### Day Center
- Providence
- Westerly
- Contracted
- Crash Cart
- Triage Process
- Treatment Room
- Clinic Rooms
- MSDS Binder
- Badge “Dots”
- Medical Records Procedures
- Location of PPE
- Supply Room

#### Alternate Site Care
- Nursing Homes and Respite
- Hospitals
- ALF
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Initials _____ Name ____________________ Initials _____ Name ____________________

Initials _____ Name ____________________ Initials _____ Name ____________________

Employee Signature ___________________________ Date ____________

Supervisor Signature __________________________ Date ____________
Additional Action/Training Required: ________________________________

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APPENDIX III: SAMPLE CONTRACT

AGREEMENT BETWEEN

INDEPENDENT LIVING FOR SENIORS, INC. d/b/a ELDERONE, AN AFFILIATE OF ROCHESTER GENERAL HEALTH SYSTEM NE

AND

___________________________________________

FOR THE PROVISION OF ________________________________

CONTRACT START DATE ________________

MONTH, DAY, YEAR

This agreement, entered into this __________ day of ______________, 20_______ MONTH ___ YEAR

between CAPS __________________ located at ________________________________________________

herein after referred to as the “Contractor,” and INDEPENDENT LIVING FOR SENIORS, INC. d/b/a
ELDERONE, AN AFFILIATE OF ROCHESTER GENERAL HEALTH SYSTEM, a New York not-for-
profit corporation with offices at 490 East Ridge Road, Rochester, New York 14621 (“ElderONE”)

WHEREAS, ElderONE wishes to enter into an agreement with the Contractor for the purpose of providing___
________________________________________, the ElderONE program and Contractor is ready, willing and able

MONTH, DAY, YEAR

to provide such services;

NOW, THEREFORE, in consideration of the mutual agreements herein contained, the parties hereby agree
upon the following terms and conditions.

A. Terms

1. The Contractor must be in compliance with all State and Federal licensing, certification and other
requirements, and have demonstrated the capacity to perform the needed contracted service(s).

2. The Contractor shall provide prescription drugs and medications services to ElderONE, at the request
of ElderONE, upon the terms and conditions specified in this Agreement, and in accordance with all
applicable federal, state and local laws, rules and regulations.
3. Both parties agree to adhere to the fee schedule set forth in Appendix A to this Agreement, which is hereby incorporated into this Agreement by reference. The fee schedule will be re-negotiated annually, when applicable.

4. This Agreement constitutes the entire agreement of the parties hereto, and all previous communications between the parties, whether written or oral, with respect to the subject matter of this Agreement, are hereby superseded. No amendment, change or modification of this Agreement shall be effective unless in writing and signed by the parties hereto.

5. The term shall automatically renew for successive one (1) year terms, unless earlier terminated as hereinafter provided.

B. General

1. ElderONE and the Contractor shall consult and cooperate with each other regarding all matters pertinent to carrying out the provisions and purposes of this Agreement.

2. The Contractor shall follow participant care guidelines established by ElderONE.

3. The Contractor is responsible for supervision of participant care and shall render covered services in accordance with the covered participant’s plan of care (except in cases of emergency as defined in 42 CFR 460.100(c)).

4. Notwithstanding any other provision in this Agreement, ElderONE shall ensure that any service provided to its participants pursuant to this Agreement complies with all pertinent federal, state and local statutes, rules and regulations.

5. ElderONE shall provide orientation regarding the scope of services required and ElderONE policies and procedures including participants’ rights, documentation and reporting requirements to the Contractor and provide the Provider Manual for reference.

6. The Contractor agrees that in carrying out its activities under the terms of this Agreement, that it shall not discriminate against any employee or participant due to race, color, creed, sex, age, disability, marital status or national origin and that at all times it will abide by applicable provisions of the Human Rights Law of the State of New York.

7. All services performed by Contractor shall be consistent and comply with ElderONE’s contractual obligations set forth in the New York State Department of Health ("NYSDOH") contract and the Program Agreement.
8. The Contractor will ensure that pertinent contracts, books, documents, papers and records of their operations, that pertain to participants treated/served through this Agreement, are available to properly qualified personnel of ElderONE, Centers for Medicare and Medicaid Services (“CMS”), NYSDOH, United States Department of Health and Human Services (“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 subcontract, or from the date of completion of any audit, or pursuant to the timeframes established in 42 CFR Part 460 (The Medicare and Medicaid Programs; Programs of All-Inclusive Care for the Elderly Regulations), whichever is later.

9. The Contractor will submit reports and data when requested by ElderONE including reports relating to care, when applicable.

10. The Contractor shall not, in whole or in part, assign, convey, transfer, sublet, mortgage, pledge, hypothecate, grant any security interest in, or otherwise dispose of this Agreement, or of its right, title or interest therein or its power to execute this Agreement, to any other agency on or entity without the prior written consent of ElderONE.

11. The Contractor shall comply with the provisions set forth in Appendix B, attached hereto and made a part hereof. To the extent that the express terms of this Agreement and Appendix B conflict, the terms of Appendix B shall govern.

12. No provision of this Agreement is to be construed as contrary to the provisions of Article 44 of the New York Public Health Law and implementing regulations to the extent that it does not conflict with 42 CFR Part 460.

13. The credentialing process of the Contractor will be reviewed and approved by ElderONE and ElderONE will audit the credentialing process on an ongoing basis.

14. Specific delegated activities and reporting responsibilities, including the amount, duration and scope of services to be provided, if applicable, are addressed in the recommended service specific Appendix A.

15. The Contractor shall participate in and comply with quality assurance and utilization review programs, including grievance and appeal procedures, the promotion of participant rights, and the monitoring and evaluation of the ElderONE Program.

16. The ElderONE Director of Health Plan Operations will monitor the Contractor’s compliance with this Agreement. The Director of Health Plan Operations is the ElderONE liaison under this Agreement.
17. In the event of a dispute, the parties will consider the use of mediation and/or arbitration to resolve the dispute instead of litigation except for actions involving equity or injunctive relief and/or ElderONE failure to pay Contractor any amounts due. The Commissioner of NYSDOH is not bound by arbitration or mediation decisions. Arbitration or mediation must occur within New York State and the Commissioner will be given notice of all issues going to arbitration or mediation, and copies of all decisions. Disputes hereunder related to matters covered by the Department of Health contract shall be resolved using NYSDOH’s interpretation of the terms and provisions under the NYSDOH contract with ElderONE.

18. **PROVIDER MANUAL** The Contractor agrees to comply with the ElderONE Provider Manual. The Contractor agrees to instruct staff assigned to work at ElderONE, or with ElderONE participants, on the contents of the Provider Manual.

19. In the performance of its obligations hereunder, Contractor shall be and act at all times as an independent contractor to ElderONE. Except as provided herein, Contractor shall not be under the direction or supervision of ElderONE in the performance of its duties hereunder. Nothing herein shall be construed to create an employer-employee relationship between ElderONE and Contractor, nor shall Contractor’s staff have any claim under this Agreement or otherwise against ElderONE for vacation pay, sick leave, retirement benefits, social security, workmen’s compensation, disability or unemployment insurance benefits, or any employee benefits of any kind.

20. The Contractor shall not charge or accept any fee from a participant or any participant’s representative for services covered under the ElderONE plan. Nor shall the Contractor charge or accept any fee or gift from any participant or participant’s family.

21. **PROHIBITION ON USE OF FEDERAL FUNDS FOR LOBBYING** Provider agrees, pursuant to Section 1352, Title 31, United States Code, and 45 CFR Part 93 not to expend federally appropriated funds received under this Agreement 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 provider agrees to submit the Certification Regarding Lobbying, attached as Appendix C, if this Agreement exceeds $100,000.

If any funds other than federally appropriated funds have been paid or will be paid to any person for 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 Agreement or the underlying Federal grant and the agreement exceeds $100,000 the Contractor agrees to complete and submit the attached Standard FormLLL, “Disclosure of Lobbying Activities” (Appendix D).
C. Contractor

1. The Contractor agrees to provide services as authorized by the ElderONE primary care physician.

2. The Contractor agrees that assignment and/or delegation of this Agreement is prohibited unless prior written approval is obtained from ElderONE.

3. The Contractor shall agree to participate with the interdisciplinary team and deliver treatment in accordance with each patient’s plan of care.

4. The Contractor shall agree to be accessible to participants.

5. All Contractor personnel who have the potential to interact with ElderONE participants shall receive a health status examination to be conducted prior to employment, and thereafter no less than annually, including but not limited to: (a) serological proof of Rubella antibodies or documented live rubella vaccine given after age one (1); (b) free from active Tuberculosis as demonstrated by a negative PPD skin test for TB within the previous year, or chest x-ray and written evaluation ruling out active tuberculosis if the PPD is positive; (c) Hepatitis B vaccine, serological proof of Hepatitis B immunity or signed declination; (d) for individuals born after 1956: serological proof of Rubeola antibodies, or proof of two (2) live Rubeola vaccinations, or one (1) MMR and a Rubeola, or two (2)MMR doses administered after age one (1) and a minimum of thirty (30) days apart; and (e) determination made by the Contractor that he/she is free from health impairments which are of potential risks to ElderONE participants including addiction to behavior altering substances. Records will be maintained by the Contractor and made available to ElderONE upon request. The Contractor shall provide evidence satisfactory to ElderONE that each employee meets ElderONE’s health requirements prior to employment by the Contractor.

D. Jurisdiction/Choice of Law

This Agreement shall be governed by the laws of the State of New York and the venue for any action to interpret or enforce the Agreement shall be Monroe County, New York.

E. Insurance

Contractor shall maintain general and commercial liability insurance, professional liability insurance, workers’ compensation coverage and such extended coverage insurance as may be necessary to protect itself and ElderONE from loss or liability in connection with Contractor’s performance of services pursuant to this Agreement. The amount of such coverage shall be a minimum of $1,000,000 for each occurrence with an aggregate limit of $3,000,000. Prior to commencing work, Contractor shall provide a certificate of insurance evidencing the aforesaid coverage. In the event of any material change in the insurance coverage required by this Agreement, the Contractor shall notify ElderONE in writing within five (5) days of such change.
F. Billing and Payment

1. Contractor agrees to furnish only those services authorized by ElderONE except in emergency situations. Contractor agrees to accept payment from ElderONE as payment in full, and not bill participants, CMS, the NYSDOH administering agency, or private insurers. Contractor agrees to hold harmless CMS, NYSDOH and ElderONE participants if ElderONE does not pay for services performed by the Contractor in accordance with this Agreement.

2. ElderONE shall reimburse the Contractor according to the fee schedule included as Appendix A.

3. Contractor agrees to submit claims within ninety (90) days of providing services.

4. As applicable: ElderONE agrees to make payment to Contractor within thirty (30) days of receipt of a bill for the services rendered to ElderONE participants that is transmitted via the internet or electronic mail, or forty-five (45) days of receipt of a claim or bill for services rendered that is submitted by other means, such as paper or facsimile, except in a case where the obligation of ElderONE is not reasonably clear, or when there is a reasonable basis supported by specific information available for review that such bill for services rendered was submitted fraudulently. Whenever the obligation of ElderONE to pay is not reasonably clear due to a good faith dispute regarding the eligibility of a person for coverage, the liability of another insurer or corporation or organization for all or part of the bill, the amount of the bill, the benefits covered under a contract or agreement, or the manner in which services were accessed or provided, ElderONE shall pay any undisputed portion of the bill and notify the health care provider or participant in writing within thirty (30) days of the receipt of the bill.

5. Payment by ElderONE for the sums herein contracted for shall be made upon the monthly submission of invoice(s), supported with such information and documentation necessary to substantiate the invoice(s). The supporting documentation shall include, but not be limited to, the participant’s name, dates of service and complete CMS 1500 or UB92 data elements with CPT codes when applicable. Invoices shall be prepared and submitted in accordance with the terms of this Agreement and in accordance with any additional instructions provided by ElderONE.

6. Contractor is to maintain records of all financial transactions related to the provision of services under this Agreement. Such records shall be kept in accordance with generally accepted accounting practices and each transaction shall be fully documented. Books and records shall be made available, as requested, to NYSDOH.
G. Omnibus Reconciliation Act

Contractor hereby agrees that, subject to the legality and applicability of Section 952 of the Omnibus Reconciliation Act of 1980 and implementing regulations:

1. Until the expiration of four (4) years after the furnishing of services under this Agreement, Contractor shall make available, upon written request of an appropriate federal official, this Agreement and any books, documents and records of Contractor that are necessary to certify the nature and extent of the costs of such services; and

2. If Contractor carries out any of the duties of this Agreement through a subcontract with a value or cost of $10,000 or more over a twelve (12) month period, with an organization related to Contractor, such subcontract shall contain a clause similar to subparagraph (i) above, making available the subcontract and the books, documents and records of such related organization which are necessary to verify the nature and extent of the costs of the subcontracted services, upon written request of an appropriate federal official.

H. Notices

All written notices required or permitted under this Agreement must be in writing and delivered by certified (return receipt requested) or Registered First Class United States mail, postage prepaid to the address set forth in this Agreement or to such other address as may be designated pursuant to written notice given in accordance with this Section. The date of deposit of any notice in a United States Post Office or Post Office Box with all postage prepaid shall be deemed the date of delivery thereof.

Notices shall be addressed as follows:

<table>
<thead>
<tr>
<th>Contractor</th>
<th>ElderONE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>ElderONE</td>
</tr>
<tr>
<td>Address</td>
<td>490 East Ridge Road</td>
</tr>
<tr>
<td></td>
<td>Rochester, New York 14621</td>
</tr>
<tr>
<td></td>
<td>Attn: Executive Director</td>
</tr>
</tbody>
</table>

With a copy to:

| Rochester General Health System |
| 1425 Portland Avenue |
| Rochester, New York 14621 |
| Attn: General Counsel |
I. Termination

1. **WITHOUT CAUSE** Either party may terminate this Agreement without cause and without any penalty upon sixty (60) days written notice.

2. **FOR CAUSE** In the event of a material breach of this Agreement, the non-breaching party may, at any time after the expiration of thirty (30) days following written notice of the breach to the other party, terminate the Agreement by further written notice of termination to the other party; provided, however, that if the breaching party has cured the breach prior to receipt of written notice of termination, the Agreement shall remain in effect and the non-breaching party shall be limited to damages as its remedy.

Either party may terminate this Agreement immediately upon written notice in the event that either party has had a license, operating certificate permit or Federal waiver of any kind which is required for operation, revoked, suspended or not renewed by any regulatory, reimbursing, or licensing agency (including but not limited to NYSDOH, CMS, New York State Department of Transportation) for any reason.

This Agreement may be terminated when ElderONE or NYSDOH determines that the contractor is responsible for any of the following which includes but is not limited to action(s) which threaten the safety or welfare of ElderONE participants, significant substantiated complaints, submitting claims to the plan for services not delivered, and/or the refusal to participate in ElderONE’s quality improvement program.

The Contractor may terminate the Agreement upon the implementation of an adverse reimbursement change as described in Section C(3) of Appendix B provided the Contractor objected to the change within thirty (30) days of notification of the change.

J. Confidentiality

All information concerning ElderONE which may be made available to Contractor’s personnel by ElderONE shall be deemed to be confidential, and Contractor’s personnel shall not be permitted or required by Contractor to disclose any such information to any third party without the express written consent of ElderONE. Contractor agrees that its personnel who work for ElderONE under this Agreement shall use the information they acquire during the course of the engagement solely for ElderONE benefit, and that such information may not be used by any of Contractor’s personnel, whether or not assigned to work for ElderONE, for any other purpose whatsoever.

Medical records of ElderONE participants shall be confidential and shall be disclosed to and by other persons within the Contractor’s organization only as necessary to provide health care or otherwise in accordance with applicable law.
K. Rochester General Health Systems: Compliance Program Confirmation and Cooperation Compliance Program

Contractor understands and acknowledges that ElderONE participates in the Rochester General Health System Corporate Compliance Plan and that ElderONE promotes a compliance attitude with a culture that seeks to foster the prevention, detection and resolution of instances of misconduct. In furtherance thereof, Contractor shall cooperate with ElderONE and Rochester General Health System during the term of this Agreement. Contractor shall immediately notify Rochester General Health System’s Compliance Officer, at 1-877-647-6725 of any violation of any applicable law, regulation, third party payer requirement or breach of Rochester General Health System’s Program of which Contractor or its employees or agents becomes aware during the term of this Agreement, Contractor shall instruct its employees and agents who provide services under this Agreement of this requirement and shall obtain their written acknowledgment of same prior to any individual’s provision of services to ElderONE.

L. Non-Exclusion

Contractor represents and warrants to ElderONE that neither it nor any of its affiliates: (a) are excluded from participation in any federal health care program, as defined under 42 U.S.C. § 1320a-7b(f), for the provision of items or services for which payment may be made, either directly or indirectly (e.g., through inclusion in a Medicare cost report), under such federal health care program; and (b) has arranged or contracted (by employment or otherwise) with any employee, contractor or agent that such party or its affiliates knows or should know are excluded from participation in any federal program, to provide items or services hereunder. Contractor represents and warrants to ElderONE that no final adverse action, as such term is defined under 42 U.S.C. § 1320a-7e(g), has occurred or is pending or threatened against such Contractor or its affiliates or, to their knowledge, against any employee, subcontractor or agent engaged to provider services under this Agreement.
M. Investigation, Inquiries and Reviews

Contractor is aware that ElderONE is relying upon Contractor’s expertise in those areas set forth in the Agreement, including, but not necessarily limited to, proper documentation, coding and billing. Accordingly, Contractor shall, during the term of this Agreement and for a period of ten (10) years following the term of this Agreement, notify ElderONE within ten (10) business days of learning of any (a) complaint, investigation, inquiry or review by any governmental agency or third party payer regarding any of the items or services provided hereunder or these contractual arrangements or substantially similar items, services or arrangements provided to any other client of Contractor or their affiliates, or (b) any final adverse action being taken against any client of Contractor or their affiliates in connection with substantially similar items, services or arrangements. Such notice shall include a description of the matters at issue. If an investigation or inquiry referenced in the preceding sentence results in the issuance of a complaint or indictment during the course of this Agreement, ElderONE shall have the right to terminate this Agreement without cause, penalty or damages; provided, however, that Contractor shall be entitled to reimbursement for actual services provided up to the effective date of such termination.

N. Standards of Performance

Contractor must perform all services in compliance with applicable Federal and State requirements, laws, rules, regulations, and in compliance with all agency bylaws, rules, regulations, policies and procedures with respect to service delivery, participant rights, quality assessment and performance improvement activities.

O. Hold Harmless/Indemnification

Each party covenants to hold the other party harmless against; and to indemnify the other party for, all losses, damages, expenses, liabilities and any other costs, including attorneys’ fees, arising out of or incurred in connection with such party’s breach or default in performance of this Agreement or arising out of the negligence or other unlawful malfeasance or non-feasance by such party or its servants, agents, employees or agencies in relation to this Agreement. Each party further covenants to the other that, in the event any claim or demand is asserted against it which may result in indemnification liability to the other, it will give prompt written notice thereof to the other party and will cooperate in the investigation of any such claim and/or the defense of any action arising therefrom.
IN WITNESS WHEREOF, the parties have executed this Agreement as of the date first indicated above.

INDEPENDENT LIVING FOR SENIORS, INC.
d/b/a ELDERONE, AN AFFILIATE OF ROCHESTER GENERAL HEALTH SYSTEM

By ______________________________
Name _____________________________
Title ______________________________

NAME

By ______________________________
Name _____________________________
Title ______________________________
APPENDIX A

Service:

COMMUNITY PHYSICIAN RESPONSIBILITIES AS PRIMARY PROVIDER FOR ELDERONE PARTICIPANTS

Primary Care Provider will:

1. Agree to support the ElderONE mission to provide nursing home eligible patients an alternative to nursing home placement, with in home care, in a cost effective manner.

2. Provide continuity of medical care in all areas of care including office, hospital and nursing home, for participants enrolled in ElderONE.

3. Provide comprehensive handoff of information for all transitions of care.

4. Understand and abide by ElderONE participant rights in service delivery practices.

5. Provide Medicare and Medicaid covered services, as appropriate.

6. Provide an extended range of other services to ElderONE participants, which may include such aspects as prevention and health maintenance education.

7. Maintain 24 hour coverage in collaboration with ElderONE.

8. Order consultations with specialty providers using only providers within the ElderONE Provider Network. Note: All referrals to out-of-network providers require pre-approval by the ElderONE medical director or designee.

9. Complete an initial history and physical for each new participant, within the first 30 days of admission, and follow-up comprehensive reviews no less than once every 6 months at the semi-annual team assessment, at any reassessment due to a change in participant status, and at assessments performed at the request of a participant. Note: Initial enrollees are scheduled for follow-up appointments, initially 1-2 months for the first 6 months, to ensure comprehensive review of the transition process including:
   a. transition of consultants
   b. completion of written healthcare proxy
   c. delineation of overall goals of care [longevity, function or comfort],
   d. medication reconciliation
10. Maintain admitting privileges at contracted hospitals. If physician does not have admitting privileges, ElderONE must be notified and prior approval, by the Medical Director and the ElderONE Executive Administrator, must be obtained before entering into the contract.

Admit for all medical hospitalizations, and maintain role as medical consultant in surgical, psychiatric and rehabilitation hospitalizations or make other arrangements with the ElderONE Medical Director.

Work with ElderONE and ElderONE Medical Director to deliver high quality, cost effective medical care including:

- Use of ElderONE formulary, when applicable
- Use of geriatric clinical guidelines, when appropriate (Ex: American Geriatrics Society (AGS), American Medical Directors Association (AMDA), National PACE Association Primary Care Committee (NPA PCC).
- Consult with ElderONE Medical Director and ElderONE Consultant Pharmacist for all prescription medication costing greater than $200 per month.
- Consult with ElderONE Medical Director or designee regarding all anticipated hospitalizations or rehabilitation needs, so that alternatives may be explored, when clinically appropriate.
- Participation in all Quality Assurance Performance Improvement (QAPI) initiatives.

11. Participate in team meetings as scheduled or requested by the team or provide appropriate alternative.

12. Communicate with Interdisciplinary Team, other providers and designee’s as determined by the ElderONE Medical Director.

13. Provide Physician collaborative oversight to the ElderONE assigned Nurse Practitioner according to the Collaborative Practice Agreement and NYS Education Department

14. Complete all documentation in a timely manner and submit claims for all encounters (in-person, telephonic, etc.) in a timely manner.

Ensure documentation supports the submitted diagnosis and the clinical review process to ensure appropriate diagnostic specificity is captured.
## Rate of Payment

### Contact Information

<table>
<thead>
<tr>
<th>Claims</th>
<th>Reports and Other Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mail all claims to:</td>
<td>Independent Living for Seniors, Inc. d.b.a ElderONE</td>
</tr>
<tr>
<td>Independent Living for Seniors, Inc. d.b.a ElderONE</td>
<td>Att: ElderONE Finance Department</td>
</tr>
<tr>
<td>c/o Tristate Benefit Solutions</td>
<td>100 Kings Highway South</td>
</tr>
<tr>
<td>619 Oak St</td>
<td>Rochester, NY 14617</td>
</tr>
<tr>
<td>Cincinnati, OH 45206</td>
<td>585-922-1034</td>
</tr>
<tr>
<td>Toll-free number 1-866-479-5050</td>
<td>Fax: 585-922-1046</td>
</tr>
</tbody>
</table>

For electronic submission of professional claims, contact MD On-Line at 888-499-5465 or visit [www.tbsmdl.com](http://www.tbsmdl.com). For submission of institutional claims, visit [www.emdeon.com](http://www.emdeon.com). The TBS contact for EDI is John Feledy at 513-569-5049 or email at john_feledy@trihealth.com.
APPENDIX B

(Revised 3/1/11)

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

Notwithstanding any other provision of this agreement, contract, or amendment (hereinafter “the Agreement” or “this Agreement”) the parties agree to be bound by the following clauses which are hereby made a part of the Agreement. Further, if this Agreement is between a Managed Care Organization and an IPA, or between an IPA and an IPA, such clauses must be included in IPA contracts with providers, and providers must agree to such clauses.

A. DEFINITIONS FOR PURPOSES OF THIS APPENDIX

“Managed Care Organization” or “MCO” shall mean the person, natural or corporate, or any groups of such persons, certified under Public Health Law Article 44, who enter into an arrangement, agreement or plan or any combination of arrangements or plans which provide or offer, or which do provide or offer, a comprehensive health services plan.

“Independent Practice Association” or “IPA” shall mean an entity formed for the limited purpose of arranging by contract for the delivery or provision of health services by individuals, entities and facilities licensed or certified to practice medicine and other health professions, and, as appropriate, ancillary medical services and equipment, by which arrangements such health care providers and suppliers will provide their services in accordance with and for such compensation as may be established by a contract between such entity and one or more MCOs. “IPA” may also include, for purposes of this Agreement, a pharmacy or laboratory with the legal authority to contract with other pharmacies or laboratories to arrange for or provide services to enrollees of a New York State MCO.

“Provider” shall mean physicians, dentists, nurses, pharmacists and other health care professionals, pharmacies, hospitals and other entities engaged in the delivery of health care services which are licensed, registered and/or certified as required by applicable federal and state law.

B. GENERAL TERMS AND CONDITIONS

1. This Agreement is subject to the approval of the New York State Department of Health and if implemented prior to such approval, the parties agree to incorporate into this Agreement any and all modifications required by the Department of Health for approval or, alternatively, to terminate this Agreement if so directed by the Department of Health, effective sixty (60) days subsequent to notice, subject to Public Health Law §4403(6) (e). This Agreement is the sole agreement between the parties regarding the arrangement established herein.
2. Any material amendment to this Agreement is subject to the prior approval of the Department of Health, and any such amendment shall be submitted for approval at least thirty (30) days, or ninety (90) days if the amendment adds or materially changes a risk sharing arrangement that is subject to Department of Health review, in advance of anticipated execution. To the extent the MCO provides and arranges for the provision of comprehensive health care services to enrollees served by the Medical Assistance Program, the MCO shall notify and/or submit a copy of such material amendment to DOH or New York City, as may be required by the Medicaid managed care contract between the MCO and DOH (or New York City) and/or the Family Health Plus contract between the MCO and DOH.

3. Assignment of an agreement between an MCO and (1) an IPA, (2) institutional network provider, or (3) medical group provider that serves five percent or more of the enrolled population in a county, or the assignment of an agreement between an IPA and (1) an institutional provider or (2) medical group provider that serves five percent or more of the enrolled population in a county, requires the prior approval of the Commissioner of Health.

4. The Provider agrees, or if the Agreement is between the MCO and an IPA or between an IPA and an IPA, the IPA agrees and shall require the IPA’s providers to agree, to comply fully and abide by the rules, policies and procedures that the MCO (a) has established or will establish to meet general or specific obligations placed on the MCO by statute, regulation, or DOH or SID guidelines or policies and (b) has provided to the Provider at least thirty (30) days in advance of implementation, including but not limited to:

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

5. The Provider or, if the Agreement is between the MCO and an IPA, or between an IPA and an IPA, the IPA agrees, and shall require its providers to agree, to not discriminate against an enrollee based on color, race, creed, age, gender, sexual orientation, disability, place of origin, source of payment or type of illness or condition.

6. If the Provider is a primary care practitioner, the Provider agrees to provide for twenty-four (24) hour coverage and back up coverage when the Provider is unavailable. The Provider may use a twenty-four (24) hour back-up call service provided appropriate personnel receive and respond to calls in a manner consistent with the scope of their practice.

7. The MCO or IPA which is a party to this Agreement agrees that nothing within this Agreement is intended to, or shall be deemed to, transfer liability for the MCO’s or IPA’s own acts or omissions, by indemnification or otherwise, to a provider.

9. To the extent the MCO enrolls individuals covered by the Medical Assistance and/or Family Health Plus programs, this Agreement incorporates the pertinent MCO obligations under the Medicaid managed care contract between the MCO and DOH (or New York City) and/or the Family Health Plus contract between the MCO and DOH as if set forth fully herein, including:

a. the MCO will monitor the performance of the Provider or IPA under the Agreement, and will terminate the Agreement and/or impose other sanctions, if the Provider’s or IPA’s performance does not satisfy standards set forth in the Medicaid managed care and/or Family Health Plus contracts;

b. the Provider or IPA agrees that the work it performs under the Agreement will conform to the terms of the Medicaid managed care contract between the MCO and DOH (or between the MCO and New York City) and/or the Family Health Plus contract between the MCO and DOH, and that it will take corrective action if the MCO identifies deficiencies or areas of needed improvement in the Provider’s or IPA’s performance; and

c. The Provider or IPA agrees to be bound by the confidentiality requirements set forth in the Medicaid managed care contract between the MCO and DOH (or between the MCO and New York City) and/or the Family Health Plus contract between the MCO and DOH.

d. The MCO and the Provider or IPA agree that a woman’s enrollment in the MCO’s Medicaid managed care or Family Health Plus product is sufficient to provide services to her newborn, unless the newborn is excluded from enrollment in Medicaid managed care or the MCO does not offer a Medicaid managed care product in the mother’s county of fiscal responsibility.

e. The MCO shall not impose obligations and duties on the Provider or IPA that are inconsistent with the Medicaid managed care and/or Family Health Plus contracts, or that impair any rights accorded to DOH, the local Department of Social Services, or the United States Department of Health and Human Services.

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

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

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

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

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

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

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

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

1. Enrollee Non-liability. Provider agrees that in no event, including, but not limited to, nonpayment by the MCO or IPA, insolvency of the MCO or IPA, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a subscriber, an enrollee or person (other than the MCO or IPA) acting on his/her/their behalf, for services provided pursuant to the subscriber contract or Medicaid Managed Care contract or Family Health Plus contract and this Agreement, for the period covered by the paid enrollee premium. In addition, in the case of Medicaid Managed Care, Provider agrees that, during the time an enrollee is enrolled in the MCO, he/she/it will not bill the New York State Department of Health or the City of New York for Covered Services within the Medicaid Managed Care Benefit Package as set forth in the Agreement between the MCO and the New York State Department of Health. In the case of Family Health Plus, Provider agrees that, during the time an enrollee is enrolled in the MCO, he/she/it will not bill the New York State Department of Health for Covered Services within the Family Health Plus Benefit Package, as set forth in the Agreement between the MCO and the New York State Department of Health. This provision shall not prohibit the provider, unless the MCO is a managed long term care plan designated as a Program of All-Inclusive Care for the Elderly (PACE), from collecting copayments, coinsurance amounts, or permitted deductibles, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to a covered person provided that Provider shall have advised the enrollee in writing that the service is uncovered and of the enrollee’s liability therefore prior to providing the service. Where the Provider has not been given a list of services covered by the MCO, and/or Provider is uncertain as to whether a service is covered, the Provider shall make reasonable efforts to contact the MCO and obtain a coverage determination prior to advising an enrollee as to coverage and liability for payment and prior to providing the service. This provision shall survive termination of this Agreement for any reason, and shall supersede any oral or written agreement now existing or hereafter entered into between Provider and enrollee or person acting on his or her behalf.

2. Coordination of Benefits (COB). To the extent otherwise permitted in this Agreement, the Provider may participate in collection of COB on behalf of the MCO, with COB collectibles accruing to the MCO or to the provider. However, with respect to enrollees eligible for medical assistance, or participating in Child Health Plus or Family Health Plus, the Provider shall maintain and make available to the MCO records reflecting COB proceeds collected by the Provider or paid directly to enrollees by third party payers, and amounts thereof, and the MCO shall maintain or have immediate access to records concerning collection of COB proceeds.
3. If the Provider is a health care professional licensed, registered or certified under Title 8 of the Education Law, the MCO or the IPA must provide notice to the Provider at least ninety (90) days prior to the effective date of any adverse reimbursement arrangement as required by Public Health Law § 4406-c(5-c). Adverse reimbursement change shall mean a proposed change that could reasonably be expected to have a material adverse impact on the aggregate level of payment to a health care professional. This provision does not apply if the reimbursement change is required by law, regulation or applicable regulatory authority; is required as a result of changes in fee schedules, reimbursement methodology or payment policies established by the American Medical Association current procedural terminology (CPT) codes, reporting guidelines and conventions; or such change is expressly provided for under the terms of this Agreement by the inclusion or reference to a specific fee or fee schedule, reimbursement methodology or payment policy indexing scheme.

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

5. The parties agree that a claim for home health care services following an inpatient hospital stay cannot be denied on the basis of medical necessity or a lack of prior authorization while a utilization review determination is pending if all necessary information was provided before a member’s inpatient hospital discharge, consistent with Public Health Law § 4903.

**D. RECORDS ACCESS**

1. Pursuant to appropriate consent/authorization by the enrollee, the Provider will make the enrollee’s medical records and other personally identifiable information (including encounter data for government-sponsored programs) available to the MCO (and IPA if applicable), for purposes including preauthorization, concurrent review, quality assurance, (including Quality Assurance Reporting Requirements (“QARR”)), payment processing, and qualification for government programs, including but not limited to newborn eligibility for Supplemental Security Income (SSI) and for MCO/Manager analysis and recovery of overpayments due to fraud and abuse. The Provider will also make enrollee medical records available to the State for management audits, financial audits, program monitoring and evaluation, licensure or certification of facilities or individuals, and as otherwise required by state law. The Provider shall provide copies of such records to DOH at no cost. The Provider (or IPA if applicable) expressly acknowledges that he/she/it shall also provide to the MCO and the State (at no expense to the State), on request, all financial data and reports, and information concerning the appropriateness and quality of services provided, as required by law. These provisions shall survive termination of the contract for any reason.
2. When such records pertain to Medicaid or Family Health Plus reimbursable services the Provider agrees to disclose the nature and extent of services provided and to furnish records to DOH and/or the United States Department of Health and Human Services, the County Department of Social Services, the Comptroller of the State of New York, the Office of the Medicaid Inspector General, the New York State Attorney General, and the Comptroller General of the United States and their authorized representatives upon request. This provision shall survive the termination of this Agreement regardless of the reason.

3. The parties agree that medical records shall be retained for a period of ten (10) years after the date of service, and in the case of a minor, for three (3) years after majority or six (6) years after the date of service, whichever is later, or for such longer period as specified elsewhere within this Agreement. This provision shall survive the termination of this Agreement regardless of the reason.

4. The MCO and the Provider agree that the MCO will obtain consent directly from enrollees at the time of enrollment or at the earliest opportunity, or that the Provider will obtain consent from enrollees at the time service is rendered or at the earliest opportunity, for disclosure of medical records to the MCO, to an IPA or to third parties. If the Agreement is between an MCO and an IPA, or between an IPA and an IPA, the IPA agrees to require the providers with which it contracts to agree as provided above. If the Agreement is between an IPA and a provider, the Provider agrees to obtain consent from the enrollee if the enrollee has not previously signed consent for disclosure of medical records.

**E. TERMINATION AND TRANSITION**

1. Termination or non-renewal of an agreement between an MCO and an IPA, institutional network provider, or medical group Provider that serves five percent or more of the enrolled population in a county, or the termination or non-renewal of an agreement between an IPA and an institutional Provider or medical group Provider that serves five percent or more of the enrolled population in a county, requires notice to the Commissioner of Health. Unless otherwise provided by statute or regulation, the effective date of termination shall not be less than 45 days after receipt of notice by either party, provided, however, that termination, by the MCO may be effected on less than 45 days notice provided the MCO demonstrates to DOH’s satisfaction prior to termination that circumstances exist which threaten imminent harm to enrollees or which result in Provider being legally unable to deliver the covered services and, therefore, justify or require immediate termination.

2. If this Agreement is between the MCO and a health care professional, the MCO shall provide to such health care professional a written explanation of the reasons for the proposed contract termination, other than non-renewal, and an opportunity for a review as required by state law. The MCO shall provide the health care professional 60 days notice of its decision to not renew this Agreement.
3. If this Agreement is between an MCO and an IPA, and the Agreement does not provide for automatic assignment of the IPA’s Provider contracts to the MCO upon termination of the MCO/IPA contract, in the event either party gives notice of termination of the Agreement, the parties agree, and the IPA’s providers agree, that the IPA providers shall continue to provide care to the MCO’s enrollees pursuant to the terms of this Agreement for 180 days following the effective date of termination, or until such time as the MCO makes other arrangements, whichever first occurs. This provision shall survive termination of this Agreement regardless of the reason for the termination.

4. Continuation of Treatment. The Provider agrees that in the event of MCO or IPA insolvency or termination of this contract for any reason, the Provider shall continue, until medically appropriate discharge or transfer, or completion of a course of treatment, whichever occurs first, to provide services pursuant to the subscriber contract, Medicaid Managed Care contract, or Family Health Plus contract, to an enrollee confined in an inpatient facility, provided the confinement or course of treatment was commenced during the paid premium period. For purposes of this clause, the term “provider” shall include the IPA and the IPA’s contracted providers if this Agreement is between the MCO and an IPA. This provision shall survive termination of this Agreement.

5. Notwithstanding any other provision herein, to the extent that the Provider is providing health care services to enrollees under the Medicaid Program and/or Family Health Plus, the MCO or IPA retains the option to immediately terminate the Agreement when the Provider has been terminated or suspended from the Medicaid Program.

6. In the event of termination of this Agreement, the Provider agrees, and, where applicable, the IPA agrees to require all participating providers of its network to assist in the orderly transfer of enrollees to another provider.

F. ARBITRATION

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

G. IPA-SPECIFIC PROVISIONS

1. Any reference to IPA quality assurance (QA) activities within this Agreement is limited to the IPA’s analysis of utilization patterns and quality of care on its own behalf and as a service to its contract providers.
APPENDIX C

CERTIFICATION REGARDING LOBBYING

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

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

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

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

Date ________________________________

Title ___________________________________

Organization __________________________________________

Name (Please Print) ________________________________

Signature _________________________________________
Disclosure of Lobbying Activities

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

1. **Type of Federal Action**
   a. contract
   b. grant
   c. cooperative agreement
   d. loan
   e. loan guarantee
   f. loan insurance
   Select one: __________

2. **Status of Federal Action**
   a. bid/offer/application
   b. initial award
   c. post-award
   Select one: __________

3. **Report Type**
   a. initial filing
   b. material change
   Select one: __________

   For material change only:
   Year: __________
   Quarter: __________
   Date of last report: __________

4. **Type of Federal Action**
   Prime __________
   Subawardee __________
   Tier __________, if known
   Congressional District, if known: __________

5. **Federal Department/Agency**

6. **Federal Program Name/Description**
   CFDA Number, if applicable: __________

7. **Federal Action Number, if known**

8. **Award Amount, if known**
   $ __________

9. **a. Name and Address of Lobbying Registrant**
   (If Individual, Last Name, First Name, MI)
   Address _______________________________
   City _______________________________
   State _______________________________
   Zip code ______________________________

10. **b. Individuals Performing Services**
    (Including Address If Different from No. 10a)
    (Last Name, First Name, MI)
    Address _______________________________
    City _______________________________
    State _______________________________
    Zip code ______________________________
11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Signature ___________________________________________ Date: ________________________
Print/Type Name ___________________________________________
Title ______________________________________________________
Phone Number ___________________________________________

Instructions for Completion of SF-LLL, Disclosure of Lobbying Activities

This disclosure form shall be completed by the reporting entity, whether subawardee or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. Complete all items apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.

2. Identify the status of the covered Federal action.

3. Identify the appropriate classification of this report. If this is a followup report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.

4. Enter the full name, address, city, State and zip code of the reporting entity. Include Congressional District if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g. the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.
5. If the organization filing the report in item 4 checks “Subawardee,” then enter the full name, address, city, State and zip code of the prime Federal recipient. Include Congressional District, if known.

6. Enter the name of federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.

7. Enter the Federal program name or description for the covered Federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.

8. Enter the most appropriate Federal identifying number available for the Federal action identified in item 1 (e.g. Request for Proposal (RFP) number, Invitations for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency). Included prefixes, e.g. “RFP-DE-90-001”.

9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.

10. (a) Enter the full name, address, city, State and zip code of the lobbying registrant under the Lobbying Disclosure Act of 1995 engaged by the reporting entity identified in item 4 to influence the covered Federal action.
(b) Enter the full names of the individual(s) performing services, and include full address if different from 10(a). Enter Last Name, First Name and Middle Initial (MI).

11. The certifying official shall sign and date the form, print his/her name, title and telephone number.

According to the Paperwork Reduction Act, as amended, no persons are required to respond to a collection of information unless it displays a valid OMB control Number. The valid OMB control number for this information collection is OMB No. 0348-0046. Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0046), Washington, DC 20503.