

1. APPLICANT INFORMATION:

A. Provide the name and title of the individual who can legally bind your company, agency or entity to the terms of this Agreement. The person who is named here must sign the **Executory Clause**. Also be sure to provide the legal name of the company, agency or entity, along with its address and telephone number.

Requester Name: **Insert name & address of Subcontractor**
Title: _____
Organization: _____
Telephone: _____
Address: _____

Requester Name: **Insert name & address of LEAD HH**
Title: _____
Organization: **LEAD HH** _____
Telephone: _____
Address: _____

B. List the names of staff, contractors and subcontractors who will have access to the data covered by this agreement. **Alternatively, DOH is offering the option of having one LEAD person within each HEALTH HOME entity be responsible for the names that would have been listed on the DEAA. That person would be required to maintain an accounting of all those individuals who access MCD/PHI and maintain it accurately, as staff join and leave employment. The list would also need to be available for DOH or CMS audit, if required in the future.**

Also, identify staff responsible for the technical handling, data security, storage of the Medicaid Confidential Data/Protected Health Information (MCD/PHI). Please provide telephone numbers & email addresses if possible.

<u>Names:</u>	<u>Phone Numbers:</u>	<u>email addresses:</u>
1) _____	_____	_____
2) _____	_____	_____
3) _____	_____	_____
4) _____	_____	_____

TECHNICAL STAFF:

<u>Names:</u>	<u>Phone Numbers:</u>	<u>email addresses:</u>
1) _____	_____	_____
2) _____	_____	_____
3) _____	_____	_____
4) _____	_____	_____

2. PURPOSE OF PROJECT AND DATA USE:

A. Please describe why MCD/PHI is necessary to perform this project. Use of MCD/PHI for any purpose other than that listed is prohibited, unless the prior written approval of the NYSDOH has been obtained. **Subcontractor to complete:**

3. ATTESTATION REGARDING PRIVACY/SECURITY OF MEDICAID CONFIDENTIAL DATA:

Applicant, contractors and subcontractors hereby agree to note all confidentiality language for Third Party Contractors found in **Attachment A** of the DEAA, and that these citations must be included in all MOU, MOA, Subcontracts or Contract.

Applicant recognizes that all Medicaid Confidential Data/Protected Health Information (MCD/PHI) is owned by NYSDOH, and agrees that applicant is designated as Custodian of the MCD/PHI released under this DEAA. Applicant will be responsible for, in its hands or in the hands of its contractors/subcontractors for use of MCD. Applicant will also be responsible for the establishment and maintenance of security, as specified in an attached HIPAA compliant Security Document, to prevent unauthorized use of MCD. The applicant represents and warrants that such data will not be disclosed, released, revealed or showed, or access granted to any person or entity other than those listed in Section 1 of this DEAA.

Any improper use and disclosure of MCD/PHI must be reported to our Privacy Coordinator.

Applicant agrees to establish and insure that its contractors/subcontractors, if any, establish appropriate administrative, technical and physical safeguards to protect the confidentiality of the data and to prevent unauthorized use of or access to the data. The safeguards shall provide a level and scope of security that is not less than the level and scope of security established by the Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Applicant, its contractors and subcontractors agree to sign the Federal Health Insurance Portability and Accountability Act / Business Associate Agreement (HIPAA/BAA), as found in **Attachment B**, which also meets the standards set by NYSDOH.

Applicant agrees that all staff identified as having access to the MCD/PHI in any BAA, MOU, MOA, Contract, Subcontracts must match the list contained in Section 1 of the DEAA.

Applicant agrees that the statement of work to be done in the BAA, MOU, MOA, Subcontracts or Contract must match that described in Section 2 of the DEAA.

Applicant agrees that the duration of the BAA, MOU, MOA, Subcontracts or Contract must match the "start" and "end" date as stated in the DEAA.

Any description of destruction or return of MCD/PHI must match that as stated in the DEAA.

4 A. EXECUTORY CLAUSE: (MUST BE SIGNED & NOTARIZED):

CONFIDENTIALITY CERTIFICATION
BY **Subcontractor**

("Name of Applicant" and Office Held):

Insert name of Subcontractor

(Executory Clause):

It is understood by and between the parties that this Agreement shall be deemed executory to the extent of the resources available to NYSDOH Medicaid program and no liability on account thereof shall be incurred by the NYSDOH Medicaid beyond the resources available thereof.

To New York State Department of Health ("Department"):

The Applicant has requested the following Medicaid confidential data (describe data): _____

"the data") to (state purpose and legal authority): _____

for periods (dates): **Upon DEAA approval** and application will expire on (date): **Three (3) years from approval with anticipated redesignation.**

Section 1902(a) (7) of the federal Social Security Act and Section 369 (4) of the Social Services Law, require that Medicaid Confidential Data be treated as confidential and used or disclosed only for a purpose directly connected with the administration of the Medical Assistance program.

The Applicant certifies to the Department that the Applicant, its officers, employees, agents or subcontractors will adhere to these Medicaid confidentiality standards and provisions of the legal authority cited by the applicant. The Applicant will provide the following controls to ensure confidentiality of the data:

1. The data may be used only for the purpose listed in this Application.
2. Only listed Applicant staff that require the data to perform functions listed in this Application may be given access to the data. Such staff will be instructed by the Applicant in the confidential nature of the data and its proper handling.
3. The data will be secured in locked storage receptacles when the data are not under the direct and immediate control of an authorized Applicant staff member engaged in work under this Application.
4. The data, including any copies made by the Applicant, will be returned to the Department by the Applicant upon completion the Application purpose, or with prior written Department approval, the data may be destroyed by the Applicant after its use and a written confirmation provided by the Applicant to the Department of such destruction.

(Applicant): **Insert name of subcontractor** makes this Confidentiality Certification and Executory Clause as a condition for receipt of confidential Medicaid information and to ensure maintenance of confidentiality and security of the data pursuant to the aforementioned laws.

Date: _____

Signature of CEO: _____

Signer's Name: _____

Title: _____

Address: _____

State of _____

County of _____

Subscribed and sworn to before me on this _____ day of _____, 201_

Notarization

4 B. EXECUTORY CLAUSE: (MUST BE SIGNED & NOTARIZED):

CONFIDENTIALITY CERTIFICATION

BY: **LEAD HH**

Insert name of LEAD Health Home

(Executory Clause):

It is understood by and between the parties that this Agreement shall be deemed executory to the extent of the resources available to NYSDOH Medicaid program and no liability on account thereof shall be incurred by the NYSDOH Medicaid beyond the resources available thereof.

To New York State Department of Health ("Department"):

The Applicant has requested the following Medicaid confidential data (describe data): Medicaid beneficiary demographics, including but not limited to name, address, DOB, gender and CIN (client identification number)

Medicaid claims data for all categories of service, (including physician, clinics, inpatient and all pharmacy claims, by Medicaid beneficiary with appropriate units of service (Medicaid days, claims, and visits)

Eligibility data by Medicaid beneficiary including the eligibility start-end dates to facilitate enrollee recertification.

Provider demographic data by Medicaid provider, Medicaid provider addresses at which they receive correspondence (including provider type) – for all current Medicaid providers who have serviced at least one of the Health Home eligible population during historical and current time frame. (“the data”) to (state purpose and legal authority): act as a care management model to provide/coordinate comprehensive health home services for Medicaid (populations) beneficiaries with chronic medical and/or behavioral health illnesses. The DOH will provide the HH specific Medicaid claims data for each enrollee that will facilitate the provision of care management and coordination services linked to an integrated health care delivery system and community provider network. The goals of the HH are to:

- assure access to appropriate services
- improve health outcome
- reduce preventable hospitalizations and emergency room visits
- promote the use of health information technology (HIT)
- avoid unnecessary care

for periods (dates): Upon DEAA approval and application will expire three (3) years from DEAA approval unless redesignated.

Section 1902(a) (7) of the federal Social Security Act and Section 369 (4) of the Social Services Law, require that Medicaid Confidential Data be treated as confidential and used or disclosed only for a purpose directly connected with the administration of the Medical Assistance program.

The Applicant certifies to the Department that the **Insert name of LEAD HH**, its officers, employees, agents or subcontractors will adhere to these Medicaid confidentiality standards and provisions of the legal authority cited by the applicant. The Applicant will provide the following controls to ensure confidentiality of the data:

1. The data may be used only for the purpose listed in this Application.
2. Only listed Applicant staff that require the data to perform functions listed in this Application may be given access to the data. Such staff will be instructed by the Applicant in the confidential nature of the data and its proper handling.
3. The data will be secured in locked storage receptacles when the data are not under the direct and immediate control of an authorized Applicant staff member engaged in work under this Application.
4. The data, including any copies made by the Applicant, will be returned to the Department by the Applicant upon completion the Application purpose, or with prior written Department approval, the data may be destroyed by the Applicant after its use and a written confirmation provided by the Applicant to the Department of such destruction.

(Applicant): **Insert name of LEAD HH** makes this Confidentiality Certification and Executory Clause as a condition for receipt of confidential Medicaid information and to ensure maintenance of confidentiality and security of the data pursuant to the aforementioned laws.

Date: _____

Signature of CEO: _____

Signer's Name (please print): _____

Organization: **Insert name of LEAD HH**

Address: _____

State of _____

} ss.:

County of _____

Subscribed and sworn to before me on this _____ day of _____, 20__

_____ Notarization

ATTACHMENT A

CONFIDENTIALITY LANGUAGE FOR THIRD PARTY CONTRACTS

The federal Center for Medicare and Medicaid Services (CMS) requires that all contracts and/or agreements executed between the Department of Health and any second party that will receive Medicaid Confidential Data must include contract language that will bind such parties to ensure that contractor(s) abide by the regulations and laws that govern the protection of individual, Medicaid confidential level data. This notification requires that you include the following language in this contract and all future contracts that will govern the receipt and release of such confidential data:

Medicaid Confidential Data/Protected Health Information includes all information about a recipient or applicant, including enrollment information, eligibility data and protected health information.

You must comply with the following state and federal laws and regulations:

- Section 367b(4) of the NY Social Services Law
- New York State Social Services Law Section 369 (4)
- Article 27-F of the New York Public Health Law
- Social Security Act, 42 USC 1396a (a)(7)
- Federal regulations at 42 CFR 431.302, 42 C.F.R. Part 2
- The Health Insurance Portability and Accountability act (HIPAA), at 45 CFR Parts 160 and 164

Please note that MCD released to you may contain AIDS/HIV related confidential information as defined in Section 2780(7) of the New York Public Health Law. As required by New York Public Health Law Section 2782(5), the following notice is provided to you:

“This information has been disclosed to you from confidential records which are protected by state law. State law prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. Any unauthorized further disclosure in violation of state law may result in a fine or jail sentence or both. A general authorization for the release of medical or other information is NOT sufficient authorization for the release for further disclosure.”

Alcohol and Substance Abuse Related Confidentiality Restrictions:

Alcohol and substance abuse information is confidential pursuant to 42 C.F.R. Part 2. General authorizations are ineffective to obtain the release of such data. The federal regulations provide for a specific release for such data. You agree to ensure that you and any agent, including a subcontractor, to whom you provide MCD/PHI, agrees to the same restrictions and conditions that apply throughout this Agreement. Further, you agree to state in any such agreement, contract or document that the part to whom you are providing the MCD/PHI may not further disclose it without the prior written approval of the New York State Department of Health. You agree to include the notices preceding, as well as references to statutory and regulatory citations set forth above, in any agreement, contract or document that you enter into that involves MCD/PHI.

ANY AGREEMENT, CONTRACT OR DOCUMENT WITH A SUBCONTRACTOR MUST CONTAIN ALL OF THE ABOVE PROVISIONS PERTAINING TO CONFIDENTIALITY. IT MUST CONTAIN THE HIV/AIDS NOTICE AS WELL AS A STATEMENT THAT THE SUBCONTRACTOR MAY NOT USE OR DISCLOSE THE MCD WITHOUT THE PRIOR WRITTEN APPROVAL OF THE NYSDOH, MCDRC.

Applicant/Contractor

Signature:..... Date...../...../.....

Name Printed: Indicate subcontractor CEO's name here

Company: Insert name of subcontractor here

ATTACHMENT B

HIPAA Business Associate Agreement (BAA)

To be signed by CONTRACTOR that uses or discloses individually identifiable health information on behalf of a New York State Department of Health HIPAA-Covered Program

I.

- A. "Business Associate" shall mean: **Insert name of subcontractor here**
- B. "Covered Program" shall mean: **Insert name of LEAD HH**
- C. Other terms used, but not otherwise defined, in this AGREEMENT shall have the same meaning as those terms in the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act ("HITECH") and implementing regulations, including those at 45 CFR Parts 160 and 164.

II. **Obligations and Activities of Business Associate:**

- A. Business Associate agrees to not use or disclose Protected Health Information other than as permitted or required by this AGREEMENT or as Required By Law.
- B. Business Associate agrees to use the appropriate administrative, physical and technical safeguards to prevent use or disclosure of the Protected Health Information other than as provided for by this AGREEMENT.
- C. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of Protected Health Information by Business Associate in violation of the requirements of this AGREEMENT.
- D. Business Associate agrees to report to Covered Program as soon as reasonably practicable any use or disclosure of the Protected Health Information not provided for by this AGREEMENT of which it becomes aware. Business Associate also agrees to report to Covered Program any Breach of Unsecured Protected Health Information of which it becomes aware. Such report shall include, to the extent possible:
 - 1. A brief description of what happened, including the date of the Breach and the date of the discovery of the Breach, if known;
 - 2. A description of the types of Unsecured Protected Health Information that were involved in the Breach (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information were involved);
 - 3. Any steps individuals should take to protect themselves from potential harm resulting from the breach;
 - 4. A description of what Business Associate is doing to investigate the Breach, to mitigate harm to individuals, and to protect against any further Breaches; and
 - 5. Contact procedures for Covered Program to ask questions or learn additional information.
- E. Business Associate agrees to ensure that any agent, including a subcontractor, to whom it provides Protected Health Information received from, or created or received by Business Associate on behalf of Covered Program, agrees to the same restrictions and conditions that apply through this AGREEMENT to Business Associate with respect to such information.
- F. Business Associate agrees to provide access, at the request of Covered Program, and in the time and manner designated by Covered Program, to Protected Health Information in a Designated Record Set, to Covered Program in order for Covered Program to comply with 45 CFR § 164.524.
- G. Business Associate agrees to make any amendment(s) to Protected Health Information in a Designated Record Set that Covered Program directs in order for Covered Program to comply

- with 45 CFR § 164.526.
- H. Business Associate agrees to make internal practices, books, and records, including policies and procedures and Protected Health Information, relating to the use and disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of, Covered Program available to Covered Program, or to the Secretary of the federal Department of Health and Human Services, in a time and manner designated by Covered Program or the Secretary, for purposes of the Secretary determining Covered Program's compliance with HIPAA, HITECH and 45 CFR Parts 160 and 164.
 - I. Business Associate agrees to document such disclosures of Protected Health Information and information related to such disclosures as would be required for Covered Program to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR § 164.528.
 - J. Business Associate agrees to provide to Covered Program, in time and manner designated by Covered Program, information collected in accordance with this AGREEMENT, to permit Covered Program to comply with 45 CFR § 164.528.
 - K. Business Associate agrees to comply with the security standards for the protection of electronic protected health information in 45 CFR § 164.308, 45 CFR § 164.310, 45 CFR § 164.312 and 45 CFR § 164.316.

III. Permitted Uses and Disclosures by Business Associate:

- A. Except as otherwise limited in this AGREEMENT, Business Associate may only use or disclose Protected Health Information as necessary to perform functions, activities, or services for, or on behalf of, Covered Program as specified in this AGREEMENT.
- B. Business Associate may use Protected Health Information for the proper management and administration of Business Associate.
- C. Business Associate may disclose Protected Health Information as Required By Law.

IV. Term and Termination

- A. This AGREEMENT shall be effective for the term as specified in this AGREEMENT, after which time all of the Protected Health Information provided by Covered Program to Business Associate, or created or received by Business Associate on behalf of Covered Program, shall be destroyed or returned to Covered Program; provided that, if it is infeasible to return or destroy Protected Health Information, protections are extended to such information, in accordance with the termination provisions in this AGREEMENT.
- B. Termination for Cause. Upon Covered Program's knowledge of a material breach by Business Associate, Covered Program may provide an opportunity for Business Associate to cure the breach and end the violation or may terminate this AGREEMENT if Business Associate does not cure the breach and end the violation within the time specified by Covered Program, or Covered Program may immediately terminate this AGREEMENT if Business Associate has breached a material term of this AGREEMENT and cure is not possible.
- C. Effect of Termination.
 - 1. Except as provided in paragraph (c) (2) below, upon termination of this AGREEMENT, for any reason, Business Associate shall return or destroy all Protected Health Information received from Covered Program, or created or received by Business Associate on behalf of Covered Program. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.
 - 2. In the event that returning or destroying the Protected Health Information is infeasible, Business Associate shall provide to Covered Program notification of the conditions that

make return or destruction infeasible. Upon mutual agreement of Business Associate and Covered Program that return or destruction of Protected Health Information is infeasible, Business Associate shall extend the protections of this AGREEMENT to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such Protected Health Information.

V. Violations

- A. Any violation of this AGREEMENT may cause irreparable harm to the STATE. Therefore, the STATE may seek any legal remedy, including an injunction or specific performance for such harm, without bond, security or necessity of demonstrating actual damages.
- B. Business Associate shall indemnify and hold the STATE harmless against all claims and costs resulting from acts/omissions of Business Associate in connection with Business Associate's obligations under this AGREEMENT. Business Associate shall be fully liable for the actions of its agents, employees, partners or subcontractors and shall fully indemnify and save harmless the STATE from suits, actions, damages and costs, of every name and description relating to breach notification required by 45 CFR Part 164 Subpart D, or State Technology Law § 208, caused by any intentional act or negligence of Business Associate, its agents, employees, partners or subcontractors, without limitation; provided, however, that Business Associate shall not indemnify for that portion of any claim, loss or damage arising hereunder due to the negligent act or failure to act of the STATE.

VI. Miscellaneous

- A. Regulatory References. A reference in this AGREEMENT to a section in the Code of Federal Regulations means the section as in effect or as amended, and for which compliance is required.
- B. Amendment. Business Associate and Covered Program agree to take such action as is necessary to amend this AGREEMENT from time to time as is necessary for Covered Program to comply with the requirements of HIPAA, HITECH and 45 CFR Parts 160 and 164.
- C. Survival. The respective rights and obligations of Business Associate under (IV) (C) of this AGREEMENT shall survive the termination of this AGREEMENT.
- D. Interpretation. Any ambiguity in this AGREEMENT shall be resolved in favor of a meaning that permits Covered Program to comply with HIPAA, HITECH and 45 CFR Parts 160 and 164.
- E. HIV/AIDS. If HIV/AIDS information is to be disclosed under this AGREEMENT, Business Associate acknowledges that it has been informed of the confidentiality requirements of Public Health Law Article 27-F.

FOR SUB-CONTRACTOR USE:

Name: _____

Entity: _____

Signature: _____

Date: _____

FOR Insert name of LEAD HH USE:

Name: _____

Entity: **Insert name of LEAD HH**

Signature: _____

Date: _____

FOR NYS DOH OHIP USE:

Name: **Caryl Shakshober, Privacy Coordinator**

Entity: **NYS DOH Office of Health Insurance Programs**

Signature: _____

Date: _____

Completed Packet should be returned to:

**Caryl Shakshober, Privacy Coordinator
New York State Department of Health
Division of Program Development and Management
Corning Tower, OCP-720
Albany, New York 12237**