NOTE: Refer to the *Sample Network Contracts - Annotations* for explanation of specific provisions. This sample agreement is provided for illustrative purposes only; it does not constitute and cannot be relied upon as legal advice.

**SERVICES AGREEMENT**

This **SERVICES AGREEMENT** (the **"Agreement"),** effective this \_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_, 20\_\_\_ (“**Effective Date**”), by and between [***name of entity***] (“**Network Entity**”) and [***name of entity***] (“**Provider**”) (each, a “**Party**” and collectively, the “**Parties**.”)

**WHEREAS**, Network Entity arranges for the delivery of certain home and community-based services listed in **Exhibit A** to this Agreement (“**Core Services**”) by its network of participating community-based organizations in [***insert geographic area***] (“**Participating CBOs**”) for individuals with complex medical and social needs; and

**WHEREAS**, Provider desires to secure Core Services provided by Participating CBOs for Provider’s patients who meet specific written criteria to be developed by the Parties and included as **Exhibit B** to this Agreement (“**Patients**”); and

**WHEREAS**, Network Entity desires to arrange for the provision of Core Services by Participating CBOs for Patients in collaboration with Provider on the terms and conditions specified herein.

**NOW, THEREFORE,** in consideration of the foregoing and other good and valuable consideration, the validity of which is hereby acknowledged, the Parties agree as follows:

1. **Patient Referrals**. During the one-year period beginning on the date Provider first refers a Patient to Network Entity (“**Initial Performance Period**”), Provider shall make a minimum of [***insert number***] of Patient referrals for Core Services to Network Entity and Network Entity shall accept from Provider up to [***insert number***] Patient referrals for Core Services. The Parties shall negotiate in good faith a minimum and maximum number of Patient referrals for any Renewal Performance Periods (as defined in Section 7(a)).

(a) *Rate of Referrals.* Provider acknowledges and agrees that, during the Initial Performance Period, Network Entity may determine that it is necessary and prudent to put monthly caps on the number of new Patient referrals due to Participating CBO resource limitations. Accordingly, although Network Entity may accept additional Patient referrals if sufficient Participating CBO resources are available, Network Entity shall not be obligated to accept more than [***insert number***] new Patient referrals per month during the Initial Performance Period. Notwithstanding the foregoing, Provider shall make a minimum of [***insert number***] Patient referrals during each month of the Initial Performance Period. The Parties shall negotiate maximum and/or minimum referrals, if necessary, for any Renewal Performance Period(s).

(b) *Referral Process*. Provider and Network Entity shall define, implement, evaluate, and refine the process for making individual Patient referrals including, but not limited to: (i) the process by which a referral is communicated to Network Entity by Provider; (ii) the specific demographic and health information, health insurance coverage, and other data to be shared by Provider with Network Entity at the time of and subsequent to the referral; and (iii) how such information and data will be shared by the Parties and with the Participating CBOs.

(c) *Social Care Plans*. Network Entity, in cooperation with Participating CBOs, shall (i) make initial contact with each Patient referred to Network Entity within [***insert number***] business days following receipt of referral, and (ii) transmit to Provider a preliminary care plan for that Patient specifying the Core Services to be furnished by one or more Participating CBOs to address the Patient’s identified social needs (as opposed to the Patient’s medical care needs) (“**Social Care** **Plan**”) within [***insert number***]business days following initial contact with the Patient; provided, however, if despite its best efforts Network Entity is unable to contact the patient within [***insert number***] business days of the referral, Network Entity will be deemed in compliance with this Section if it follows the Provider and Network Entity’s agreed upon contact procedures, so documents, and notifies Provider within the [***insert number***]*-*day timeframe. Upon receipt of the Social Care Plan, Provider shall promptly review, revise, and approve the Social Care Plan and transmit the approved plan to Network Entity. Any updates or revisions to a Patient’s Social Care Plan shall be accomplished in the same manner. Provider and Network Entity shall cooperate to establish the specific processes and procedures (including, but not limited to, standard forms and patient information privacy and data transmission security plans) for completion and revision of Social Care Plans.

(d) *Access to Information*. Each party shall promptly respond to the other party’s reasonable requests for information relating to the provision of Core Services to Patients. As necessary and appropriate, Provider shall arrange for Network Entity and/or those Participating CBOs providing Core Services to Patients to have continued access to Patients’ medical care plans and restricted access to Provider’s electronic health record (EHR) for Patients solely for the purpose of providing Core Services to Patients; provided that any access to the EHR and any extraction of data is strictly subject to such access being permissible and compliant with all applicable Federal and State laws, including, but not limited to, the Health Insurance Portability and Accountability Act of 1996, as codified at 42 USC § 1320d through d-8 as amended by the Health Information Technology for Economic and Clinical Health Act, as incorporated in the American Recovery and Reinvestment Act of 2009, and any current and future regulations promulgated thereunder, including the federal privacy regulations contained in 45 C.F.R. Parts 160 and 164, the federal security standards contained in 45 C.F.R. Parts 160, 162 and 164, and the federal standards for electronic transactions contained in 45 C.F.R. Parts 160 and 162, all collectively referred to herein as “HIPAA Requirements.”

(e) *Documentation of Core Services*. In addition to the Social Care Plans, Network Entity, in cooperation with Participating CBOs, shall furnish to Provider in a timely manner complete and accurate documentation of all Core Services furnished to Patients. Provider and Network Entity shall cooperate to establish the specific processes and procedures (including, but not limited to, standard forms) for the generation, transmission, review, and retention of documentation of Core Services.

1. **Medicare Reimbursed Services**. The Parties acknowledge certain Core Services may qualify for Medicare reimbursement as transitional care management, primary care services, chronic care management, or complex chronic care management services (“CCM Services”). With respect to CCM Services, the Parties agree to the following for purposes of securing such reimbursement for Provider.

(a) *Network Entity’s Duties*. Network Entity, either directly or through one or more Participating CBOs, shall perform the following duties relating to the provision of CCM Services to Medicare Patients.

 (i) Provide a copy of the Provider-approved care plan to the Medicare Patient and/or caregiver in a format consistent with patient/caregiver preference.

 (ii) Arrange for qualified clinical staff to provide appropriate CCM Services consistent with Medicare Patients’ approved care plans and to properly document those services, including, but not limited to medication reconciliation, home safety assessment, and evidence-based disease prevention and health promotion programming. For purposes of this Agreement, “clinical staff” is defined as persons who work under the supervision of a physician or other qualified health care professions and who is allowed by law, regulation, and facility policy to perform or assist in the performance of a specified professional service but who does not individually report that professional service (per the 2016 CPT Code Book published by the American Medical Association).

 (iii) For each Medicare Patient receiving CCM Services:

1. Provide a means to access a member of the care team on a 24/7 basis to address acute/urgent needs in a timely manner (e.g., nurse call line).
2. Provide enhanced opportunities for communication with qualified clinical staff by telephone and asynchronous consultation methods.
3. As appropriate, coordinate with third-party organizations to meet psychosocial needs and functional deficits.
4. In collaboration with Provider, facilitate appropriate transitions of care.
5. Properly document all Core Services in Provider’s EHR (or in another manner as agreed by the Parties), including the total time spent furnishing CCM Services for each Medicare Patient each month.
6. Not seek payment from any person or entity for any work performed in connection with these duties except as provided herein.

Notwithstanding the foregoing, Network Entity makes no representation or warranty that the services provided hereunder will ultimately be reimbursed as CCM Services. Provider shall be solely responsible for documentation, compliance, and billing for CCM Services.

(b) *Provider’s Duties*. Provider shall perform the following duties relating to the provision of CCM Services to Patients who are Medicare beneficiaries (“Medicare Patients”).

(i) Train Provider’s staff regarding the processes for identifying and referring patients for CCM Services.

(ii) Discuss with and recommend CCM Services to Medicare Patients utilizing Network Entity-provided educational materials.

(iii) Document each Medicare Patient’s consent to receive CCM Services.

(iv) In collaboration with Network Entity and Participating CBOs, facilitate appropriate transitions of care for Medicare Patients receiving CCM Services.

(v) Provide general supervision of and regularly communicate with Participating CBO’s assigned staff to address specific patient care issues including, but not limited to, review and approval of care plans and revisions to care plans.

 (vi) Determine which specific CCM Services satisfy Medicare billing requirements and prepare and submit claims for reimbursement for those CCM Services.

1. **Training**.

(a) Network Entity shall ensure Network Entity and Participating CBO staff are fully trained on compliance with HIPAA requirements.

(b) Provider shall provide adequate training for Network Entity and Participating CBO staff as necessary to ensure efficient and effective access to and utilization of Provider’s EHR in compliance with HIPAA requirements.

(c) The Parties shall work collaboratively to ensure Provider, Network Entity, and Participating CBO staff are appropriately trained on policies, procedures, communications channels, documentation, and other operational needs as identified by the Parties.

1. **Evaluation**. The Parties shall cooperate fully in defining the metrics of success, including a process for compiling and analyzing data to evaluate (a) the efficiency and effectiveness of processes to deliver the Core Services to Patients; and (b) whether and to what extent the Core Services impact Patients’ health outcomes, Patient and Provider satisfaction, the cost impact on health care goods and services, and/or Participating CBO operations.
2. **Compensation**. In exchange for the services provided during the Initial Performance Period, Provider shall pay Network Entity [***insert amount***] by no later than thirty (30) days following full execution of this Agreement and each month thereafter during the Initial Performance Period. The parties acknowledge this amount is based on the maximum number of Patient referrals as stated in Section 1 of this Agreement divided by twelve months and multiplied by [***insert number***], the estimated per Patient cost to provide Core Services (inclusive of Network Entity’s direct administrative costs, program evaluation costs, and payments to Participating CBOs). If Network Entity accepts more than the maximum number of Patient referrals as stated in Section 1 of this Agreement during the Initial Performance Period, Provider shall pay Network Entity [***insert same number as above***] multiplied by the number of Patient referrals accepted in excess of such maximum. Provider shall not have any obligation to make payment directly to any Participating CBO for any Core Services furnished pursuant to this Agreement. The Parties shall negotiate in good faith regarding compensation for subsequent performance periods.

6. **Network Entity’s Representations and Warranties.** Network Entity represents and warrants the following:

(a) *Compliance*. Network Entity represents Participating CBOs have agree to provide Core Services in accordance with (i) all applicable laws and regulations, including all HIPAA Requirements and other privacy laws and fraud and abuse laws; (ii) Network Entity-approved protocols, policies, and procedures; and (iii) any applicable licensure requirements relating to delivery of Core Services. Notwithstanding the foregoing, Network Entity shall not be liable to Provider or any third party for any negligent or intentional act of a Participating CBO or Participating CBO agent in the delivery of Core Services.

(b) *No Violations***.** Neither Network Entity nor any of its officers, managers, directors, employees, or contractors has ever been (i) convicted of a criminal offense related to health care or related to the provision of services paid for by a federal or state health care program; (ii) assessed civil money penalties for an offense related to health care or related to the provision of services paid for by a federal or state health care program; (iii) excluded from participation in any federal or state health care program or from any other federal government executive branch procurement or non-procurement program or activity; or (iv) excluded by any federal agency from receiving federal contracts. .

(c) *Authority*. Network Entity represents and warrants that (i) it is duly incorporated or organized, validly existing and in good standing under the laws of the jurisdiction of its incorporation or organization; (ii) it has the power, authority and legal right to enter into this Agreement, and that it has taken all necessary corporate action to authorize execution of this Agreement; (iii) all necessary consents, approvals, and authorizations of governmental authorities and other persons required to be obtained related to the performance of this Agreement have been or will be obtained and all approvals will be in full force and effect during the Term.

7. **Term and Termination.**

(a) *Term*. The term of this Agreement shall commence as of the Effective Date and shall continue in effect for the Initial Performance Period, and then shall automatically renew for two (2) additional one (1) year terms (“**Renewal Performance Period**”), (collectively, the “**Performance Period**”), unless earlier terminated as provided herein.

(b) *Termination With Cause*. Either Party may terminate this Agreement if the other Party fails to observe or otherwise breaches any material term, condition, or covenant of this Agreement upon the expiration of thirty (30) days after the delivery of written notice to the breaching Party, which notice specifies the nature and extent of the breach, unless the breach is cured within such thirty (30) days.

(c) *Termination By Mutual Agreement*. This Agreement may be terminated at any time by mutual agreement of the Parties reduced to a writing signed by a properly authorized representative of each Party.

(d) *Termination Without Cause*. Either Party may terminate this Agreement as of the end of the Initial Performance Period by providing at least sixty (60) days prior written notice to the other Party.

8. **Miscellaneous**

(a) *Change in Law*. If there is a substantial change in applicable law, which renders any of the material terms of this Agreement unlawful or unenforceable or in violation of the applicable requirement, the Parties shall negotiate in good faith to resolve such issue, if necessary, revising the terms of this Agreement to comply with the applicable law, while retaining in effect, to the extent reasonably possible, the current business terms. With regard to minor changes in regulatory requirements impacting performance under this Agreement, Network Entity agrees to any changes to this Agreement strictly necessary to comply with such regulatory requirement.

 (b) *Independent Contractor*. Network Entity is an independent contractor of Provider, and neither Party nor the Party's employees or independent contractors are employed by, agents of, or partners or joint ventures of or with the other Party. No fiduciary or partnership relationship between the Parties is created under this Agreement.

(c) *Insurance.* Network Entity shall maintain and shall ensure any Participating CBO providing Core Services maintains adequate general liability and workers’ compensation insurance coverage issued by companies authorized to do business in the State of [***insert state***] and sufficient to cover their respective obligations hereunder.

(d) *Dispute Resolution***.** In the event of any dispute under this Agreement, the parties initially shall attempt to resolve the dispute informally by meeting as often as reasonably necessary during a thirty (30)-day period. If a good-faith effort to resolve the dispute has not produced a mutually agreeable resolution during the thirty (30)-day period, the parties may mutually agree to extend the period in which to settle their dispute, and, if no such extension is agreed upon, either party may pursue its rights in a judicial proceeding.

(e) *Confidentiality.* Neither Network Entity nor Provider shall disclose to any unauthorized third party any confidential or proprietary information collected or exchanged pursuant to this Agreement unless such disclosure is (i) required by law; (ii) authorized in writing by the other party; (iii) made to a party’s directors, managers, officers, employees, consultants, advisors, affiliates, counsel, and accountants (“Agents”) on an as-needed basis, but only if such Agent has agreed in writing to maintain confidentiality of such information. Any disclosure on the part of one Party to the other Party pursuant to this Agreement shall not constitute a transfer, assignment, or license of the same and such information shall remain the sole and exclusive property of the disclosing party.

(f) *HIPAA Business Associate Agreement*. The Parties shall enter into and adhere to a HIPAA-compliant Business Associate Agreement attached as **Exhibit C**.

 (g) *Third-Party Beneficiaries.* This Agreement is entered into by and between Network Entity and Provider for their respective benefit. Except as specifically provided herein, no third party shall have any right to enforce any right or enjoy any benefit created or established under this Agreement.

(h) *Waiver.* No waiver may be deemed to have been made unless made expressly in writing and signed by the waiving Party. The waiving by either party of a breach or violation of any provision of this Agreement shall not operate as, or be construed to be, a waiver of any subsequent breach or violation of the same or other provision hereof. No failure by either Party to insist upon the strict performance of any provision of this Agreement may be construed as depriving that Party of the right to insist on strict performance of that provision or of any other provision in the future.

(i)  *Jurisdiction***.** This Agreement and any claim of any kind under any theory of law will be governed by and construed in accordance with the laws of the State of [***insert***], including all matters of construction, validity, performance, and enforcement and without giving effect to contrary principles of conflict of laws.

(j) *Counterparts***.** This Agreement may be executed in any number of counterparts, each of which shall be deemed an original, but all of which shall constitute one and the same instrument. Signatures to this Agreement that are distributed to the parties via facsimile or other electronic means (including PDF) shall have the same effect as if distributed in original form to all Parties.

(k) *Severability***.** Each provision of this Agreement is intended to be severable. If any term or provision is illegal or invalid for any reason whatsoever, such illegality or invalidity shall not affect the validity of the remainder of this Agreement.

(l) *Notices*. Any notices required by this Agreement, from one Party to the other, shall be delivered in person, sent by e-mail message to the Party’s address indicated below, or sent by first-class mail, postage prepaid, to the party’s address indicated below.

(m) *Mutual Representation of Authority.* Each signatory to this Agreement represents and warrants to the other that they have full right, power, and authority to act on behalf of and bind the Party on whose behalf they are executing the Agreement.

 (n) *Assignment.* This Agreement may not be assigned by any Party without the prior express written approval of the other Party, except that either Party may assign this Agreement to an affiliate, successor entity, or subsidiary without the written approval of the other Party.

(o) *Entire Agreement*. This Agreement (i) constitutes the entire agreement between the Parties hereto with respect to the subject matter hereof; (ii) supersedes and replaces all prior agreements, oral or written, between the Parties relating to the subject matter hereof; and (iii) except as otherwise indicated herein, may not be modified, amended or otherwise changed in any manner except by a written instrument executed by the Party against whom enforcement is sought.

“**Network Entity”** **“Provider”**

[***insert legal business name***][***insert legal business name***]

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Signature Signature

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Date Date

Address for Notices: Address for Notices:

Attention: [***insert name of individual***] Attention: [***insert name of individual***]

[***insert address line 1***] [***insert address line 1***]

[***insert address line 2***] [***insert address line 2***]

[***insert city, state, ZIP code***] [***insert city, state, ZIP code***]

E-Mail: E-Mail:

Business Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Business Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Exhibit A – Core Services**

[***Insert Descriptions***]

**EXHIBIT B – PATIENT REFERRAL CRITERIA**

By no later than [***insert date***], the Parties shall agree to:

 (a) specific written criteria that an individual referred by Provider to Network Entity must satisfy to qualify as a Patient to receive Core Services, and

 (b) a written process by which the criteria will be applied to determine if an individual qualifies as a Patient.

Upon mutual agreement by the parties, such written criteria and processes shall be included as Exhibit B to this Agreement. Such criteria shall include but not be limited to the following: (1) the individual is not homeless at the time of referral; (2) the individual has been diagnosed with severe and persistent mental illness; and (3) the individual is not already receiving Core Services from another provider and has not refused consent to receive Core Services.

**EXHIBIT C - HIPAA BUSINESS ASSOCIATE AGREEMENT**

On its HIPAA web site, the U.S. Department of Health and Human Services has Sample Business Associate Agreement provisions: <https://www.hhs.gov/hipaa/for-professionals/covered-entities/sample-business-associate-agreement-provisions/index.html>