Arizona Regulatory Compliance Addendum

REQUIREMENTS FOR ALL MEDICAID PROGRAMS

1. **All Providers.** The following provisions apply to all Providers (except as otherwise designated) who participate in the AHCCCS program:

   1.1. Provider shall comply with all applicable Medicaid laws, regulations, including applicable sub-regulatory guidance and Contract provisions [42 CFR 457.1201(i), 42 CFR 438.230(c)(2), 42 CFR 438.3(k)].

   1.2. Provider shall register with AHCCCS as an approved service provider (i.e. AHCCCS registered provider) consistent with provider disclosure, screening, and enrollment requirements [42 CFR 457.1285, 42 CFR 438.608, 42 CFR 455.100-106, 42 CFR 455.400 - 470]. This includes, but may not be limited to, the providers providing to AHCCCS their identifying information such as name, specialty, date of birth, Social Security number, national provider identifier, Federal taxpayer identification number, and the State license or certification number of the provider. Additionally, any provider terminated from participation in the AHCCCS Medicaid Program, other XIX programs, Title XVIII or XXI programs, shall be terminated from participating with Company as a provider in any of Company's network of providers who render services to individuals eligible to receive medical assistance pursuant to Title XIX. Providers may refer to the AHCCCS website for specific requirements on Provider Registration.

   1.3. Providers must comply with the AHCCCS Minimum Subcontract Provisions (MSPs) which can be located on AHCCCS's website (www.azahcccs.gov). The MSPs are incorporated into this Addendum by reference as updated from time-to-time by AHCCCS.

   1.4. Provider's responsibilities with respect to coordination of benefits and third-party liability are stated in Company's Policies. In addition, Provider agrees to identify Medicare and other third-party liability coverage and to seek such Medicare or third-party liability payment before submitting claims to the Company.

   1.5. Provider shall coordinate the care of all members as required by Company's policies.

   1.6. A description of Provider's patient medical, dental and cost record keeping system:

   Electronic _____ Paper _____

   If electronic, system name: _____

   1.7. Provider shall cooperate with quality management programs and comply with the utilization control and review procedures specified in 42 CFR Part 456, as specified in the AMPM.

   1.8. If Provider is delivering Administrative Services, a merger, reorganization or change in ownership of Provider shall require a contract amendment and prior approval of AHCCCS.

   1.9. Provider acknowledges that AHCCCS is responsible for enrollment, re-enrollment, and disenrollment of the covered population.

   1.10. Provider shall be fully responsible for all tax obligations, Worker's Compensation Insurance, and all other applicable insurance coverage obligations which arise under the Agreement, for itself and

its employees, and AHCCCS has no responsibility or liability for any such taxes or insurance coverage.

1.11. Provider must obtain any necessary authorizations from Company or AHCCCS for services provided to eligible and/or enrolled members.

1.12. Provider must comply with encounter reporting and claims submission requirements as described in the Agreement.

1.13. Company may suspend, deny or refuse to renew or terminate the Agreement in accordance with the terms of the State Contract and applicable law and regulation.

1.14. As applicable, Company may revoke the delegation of activities or obligations or specify other remedies in instances where AHCCCS or Company determines that Provider has not performed satisfactorily [42 CFR 457.1201(i), 42 CFR 457.1233(b), 42 CFR 438.230(c)(1)(iii), 42 CFR 438.3(k)].

1.15. Provider may provide Members with factual information, but is prohibited from recommending or steering a Member in the Member's selection of a contractor.

1.16. Provider shall not structure compensation provided to individuals or entities that conduct utilization management and concurrent review activities so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee [42 CFR 457.1230(d), 42 CFR 438.210(e)].

1.17. The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Company's Contract with the State. [42 CFR 457.1233(b), 42 CFR 457.1201(i), 42 CFR 457.1233(b), 42 CFR 438.230(c)(3)(i)-(iv)].

1.18. Provider will make available, for purposes of an audit, evaluation, or inspection under paragraph (c)(3)(i) of 42 CFR 438.230, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid Members. [42 CFR 457.1233(b), 42 CFR 457.1201(i), 42 CFR 438.230(c)(3)(iv)].

1.19. The right to audit under (c)(3)(i) of 42 CFR 438.230 will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. [42 CFR 438.230(c)(3)(iv), 42 CFR 457.1233(b), 42 CFR 457.1201(i).]

1.20. If Company and Provider have a capitated arrangement/risk sharing arrangement, then the following provision is made part of the Agreement:

> If the Provider does not bill the Company (e.g., Provider is capitated), the Provider's encounter data that is required to be submitted to the Company pursuant to contract is defined for these purposes as a "claim for payment". The Provider's provision of any service results in a "claim for payment" regardless of whether there is any intention of payment. All said claims shall be subject to review under any and all fraud and abuse statutes, rules and regulations, including but not limited to Arizona Revised Statute (A.R.S.) § 36-2918, §36-2932, and §36-2957.

1.21. Provider must train its staff (including management, contractors, students, and agents) on the following aspects of the Federal False Claims Act provisions: (a) Detailed information about the Federal False Claims Act, (b) The administrative remedies for false claims and statements, (c) any State laws relating to civil or criminal liability or penalties for false claims and statements, and (d) whistleblower protections under such laws.

1.22. Provider shall adhere to the requirements of the Arizona Opioid Epidemic Act SB1001/HB2001.

2. **Advance Directives**

2.1. **If Provider is a hospital, nursing facility, hospice, or provider of home health care or personal care services, then Provider** must comply with Federal and State law regarding advance directives for adult members, 42 CFR 438.3(j)(1). Requirements include:

2.1.1. Maintaining written policies that address the rights of adult members to make decisions about medical care, including the right to accept or refuse medical care and the right to execute an advance directive. If the agency/organization has a conscientious objection to carrying out an advance directive, it must be explained in policies. A health care provider is not prohibited from making such objection when made pursuant to A.R.S. § 36-3205(C)(1);

2.1.2. Providing written information to adult members regarding an individual's rights under State law to make decisions regarding medical care, and the health care provider's written policies concerning advance directives, including any conscientious objections, 42 CFR 438.3(j)(3);

2.1.3. Documenting in the member's medical record whether or not the adult member has been provided the information, and whether an advance directive has been executed;

2.1.4. Preventing discrimination against a member because of his or her decision to execute or not execute an advance directive, and not place conditions on the provision of care to the member, because of his/her decision to execute or not execute an advance directive; and

2.1.5. Providing education to staff on issues concerning advance directives including notification of direct care providers of services, such as home health care and personal care services, of any advance directives executed by members to whom they are assigned to provide services.

2.2. **Health care providers specified in subparagraph 2.1 above** shall provide a copy of the member's executed advanced directive, or documentation of refusal, to the member's PCP for inclusion in the member's medical record.

2.3. **PCPs** which have agreements with the entities described in Section 2.1, above, shall comply with requirements of subparagraphs 2.1.1 – 2.1.5 above.

3. **Primary Care Providers.** In addition to the requirements of AMPM Policy 510, a PCP must perform the following activities:

3.1. Supervise, coordinate and provide care to each assigned member (except for well woman exams and children's dental services when provided without a PCP referral);

3.2. Initiate referrals for medically necessary specialty care;

3.3. Maintain continuity of care for each assigned member;

3.4. Maintain the member's medical record, including documentation of all services provided to the

member by the PCP, as well as any specialty or referral services including behavioral health;

3.5. Providers who serve EPSDT-aged members will use AHCCCS-approved EPSDT tracking form and standard developmental screening tools and be trained in the use of such tools;

3.6. Provide clinical information regarding member's health and medications to the treating provider (including behavioral health providers) within 10 business days of request from the provider;

3.7. If serving children, Provider must enroll as a Vaccines for Children (VFC) provider; and

3.8. Check the Arizona State Board of Pharmacy Controlled Substance Prescription Monitoring Program (CSPMP) when prescribing controlled medications in accordance with A.R.S. § 36-2606.

ALTCS PROGRAM

1. **All Providers.** In addition to those requirements that apply to all AHCCCS programs, as identified above and incorporated herein, the additional provisions below apply to all Providers who participate in the AHCCCS ALTCS program (except as designated).

2. **License and Certification.** If licensed or certified by ADHS, Provider must submit to Company its most recent ADHS licensure review, copies of substantiated complaints, and other pertinent information that is available and considered to be public information from oversight agencies.

3. **Nursing Facility Providers.** The following provisions apply to nursing facility Providers.

3.1 Provider must refund any payment received from a resident or family member (in excess of share of cost), for the period of time from the effective date of Medicaid eligibility.

3.2 Provider shall not admit a member to a nursing facility without the member first undergoing a Preadmission Screening and Resident Review (PASRR) Level I, and, if needed, a Level II screening. Level I screening is required for members entering a nursing facility to determine the presence of a diagnosis or other presenting evidence that suggests the possibility of a mental illness or intellectual disability. Level II screening, if indicated, is conducted by DES for members with an intellectual disability or by RBHA for members with a mental illness to further evaluate and make a determination as to whether the member is indeed mentally ill or has an intellectual disability; and determines whether the member needs the level of care provided in a nursing facility and/or needs specialized services. Failure to perform proper PASRR screening prior to placement of members in a nursing facility may result in Federal Financial Participation (FFP) being withheld from AHCCCS. AHCCCS will recoup any withholding of FFP from Company's subsequent capitation payment; and Company may, at its option recoup the withholding from the nursing facility which admitted the member without the proper PASRR.

3.3 Provider must have procedures in place to ensure that temporary nursing care registry personnel, including Nurse Aides, are properly certified and licensed before caring for members, in accordance with 42 C.F.R.§483.75(e)3 and (g)2. Such registry personnel must also be fingerprinted as required by A.R.S. §36-411.

4. **Nursing Facilities or Alternative HCBS Setting.** The following provisions apply to Providers that are nursing facilities or an alternative HCBS setting.

4.1 To the extent the Agreement covers specialty services, such services will be provided under a Work

Statement that sets forth the special services being purchased, including admissions criteria, discharge criteria, staffing ratios (if different from non-specialty units), staff training requirements, program description, and other non-clinical services such as increased activities.

AHCCCS COMPLETE CARE PROGRAM

1. **All Providers.** In addition to those requirements that apply to all AHCCCS programs, as identified above and incorporated herein, the additional provisions below apply to all Providers who participate in the AHCCCS Complete Care (ACC) program (except as designated).

2. **Primary Care Providers.** The following provisions apply to individual Providers:

   2.1 **Transfer of Care**. When a PCP has initiated medication management services for a member to treat a behavioral health disorder, and it is subsequently determined by the PCP that the member should be transferred to a T/RBHA/ behavioral health provider for evaluation and/or continued medication management services, the PCP shall coordinate the transfer of care to ensure and maintain continuity of care for these members in accordance with AMPM Policy 510 and 520.

3. **Homeless Clinics.** Only those members designated as SMI that request a homeless clinic as their PCP receive such assignment. SMI members assigned to a homeless clinic may be referred to out-of-network providers for needed specialty services.

RBHA PROGRAM

1. **All Providers.** In addition to those requirements that apply to all AHCCCS programs, as identified above and incorporated herein, the additional provisions below apply to all Providers who participate in Company's AHCCCS RBHA program (except as designated).

2. Provider agrees to abide by all applicable material terms and conditions of the applicable State Contract for the provision of covered services. Provider's compliance with the applicable State Contract specifically includes, but is not limited to, the requirements contained herein and the Agreement.

3. **Provider Registration Requirements.** Provider shall have a license, registration, certification or accreditation in conformance with AMPM Policy 310-B and AMPM Exhibit 300-2A, as applicable, or other state or federal law and regulations; and specifically:

   3.1 Register with AHCCCS in conformance with applicable AHCCS requirements and consistent with provider disclosure, screening, and enrollment requirements [42 CFR 457.1285, 42 CFR 438.608(b), 42 CFR 455.100-106, 42 CFR 455.400 - 470];
   3.2 Obtain a unique National Provider Identifier (NPI);
   3.3 For specific requirements on Provider Registration, refer to the AHCCCS Website.

4. **Licensed Inpatient Facility, Behavioral Health Residential, or Therapeutic Foster Care (TFC) Facility** shall comply with Company's quality management and medical management programs.

5. Provider shall assist members in understanding their right to file grievance and appeals in conformance with all AHCCCS Grievance and Appeal System and member rights policies.

6. Provider shall report all suspected Fraud, Waste, and Abuse (FWA) to AHCCCS-OIG regardless of funding source.

7. Company may designate information related to subcontracts as confidential but may not withhold information from AHCCCS as proprietary. Information designated as confidential may be disclosed by AHCCCS as required by law.

8. Provider and Provider's employees shall participate in and cooperate with Company's required training and orientation programs, including AHCCCS required trainings.

9. Provider shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition of the member [42 CRF 438.210(a)(3)(ii)].

10. **Providers licensed as a Level 1 facility or a Residential facility** must accept <u>all</u> referrals from Company.

    10.1 For providers licensed as a Residential facility that serves juveniles, facilities must comply with the relevant provisions of ARS § 36-1201.

11. **Providers licensed as an inpatient facility, Behavioral Health Residential or Therapeutic Foster Care (TFC)** must comply with Contractor's quality management and medical management programs.

12. **Homeless Clinics**. Only those members designated as SMI that request a homeless clinic as their PCP receive such assignment. SMI members assigned to a homeless clinic may be referred to out-of-network providers for needed specialty services.

13. **Nursing Facilities.** Providers that are a nursing facility must ensure that temporary nursing care registry personnel, including Nurse Aides, are properly certified and licensed before caring for members, in accordance with 42 CFR 483.75(e)(3) and (g)(2). Provider must also ensure that these registry personnel are fingerprinted as required by A.R.S. § 36-411.

14. **Nursing Facilities and Assisted Living Facilities**. All contracts with a nursing facility or assisted living facility must include Work Statements that outline the special services being purchased, including admission criteria, discharge criteria, staffing ratios (if different than non-specialty units), staff training requirements, program description and other non-clinical services such as increased activities.

15. **SABG and MHGB Grants**. Providers receiving Substance Abuse Block Grant (SABG) on Mental Health Block Grant (MHGB) funds must obtain and maintain an Inventory of Behavioral Health Services (I-BHS) number through Substance Abuse Mental Health Services Administration (SAMHSA).

16. **Prevention Service Delivery Subcontracts.** Prevention subcontracts must be specific to prevention and separate from subcontracts for other covered services. If the Agreement subcontracts for prevention, Provider must:

    16.1 Comply with the Strategic Prevention Framework (SPF) Model;

    16.2 Develop a prevention budget utilizing the approved AHCCCS template;

    16.3 Develop a prevention logic model to specify to Company the work to be performed; type, duration and scope of the prevention strategy to be delivered; and approximate number of participants to be served. The Contractor shall utilize the templates developed by AHCCCS, as appropriate;

16.4 Describe to Company the evaluation methods to monitor performance and the specific reporting requirements;

16.5 Implement primary prevention interventions that are Evidence Based (EBPs), Research Based (RBPs), or Promising Practices (PPs) according to peer reviewed journals and best practice lists as identified by AHCCCS. Innovative prevention interventions may be administered at a ratio of one innovative intervention per every one EBP/RBP/PPs being implemented by the subcontractor. Subcontractor Innovative Prevention Program Interventions are to be approved by AHCCCS and submitted to AHCCCS utilizing approved protocol, as specified in Section F, Attachment F3, Contractor Chart of Deliverables;

16.6 Implement all Center for Substance Abuse Prevention (CSAP) strategies, per CSAP guidelines; Information Dissemination, Education, Community Based Process, Identification and Referral, Alternatives, and Environmental. Serve the following Institute of Medicine (IOM) populations per community need: universal (direct and indirect), selective, and indicated;

16.7 Require all prevention staff to complete the Substance Abuse Prevention Skills Training (SAPST), or the AHCCCS designated equivalent training, within 6 months of date of hire and;

16.8 Comply with relevant SABG requirements.

ADES/DDD PROGRAM

1. **All Providers**. In addition to those requirements that apply to all AHCCCS programs, as identified above and incorporated herein, the additional provisions below apply to all Providers that are contracted to provide Acute Care Services to individuals who are eligible for services through the Arizona Department of Economic Security/Division of Developmental Disabilities ("ADES/DDD") programs to provide long term and medical care to persons with developmental disabilities who are eligible for ALTCS.

   1.1 Provider shall comply with all requirements applicable to all Medicaid programs as described above. Additionally, and to the extent applicable, where a government payor, including but not limited to, AHCCCS, CMS, etc., is identified in the requirements for all Medicaid programs, that provision shall be deemed to also include ADES/DDD in addition to any other government payor.

   1.2 The Agreement incorporates by reference all applicable terms and conditions of the agreement between Company and ADES/DDD.

   1.3 Provider acknowledges that ADES/DDD is responsible for enrollment, re-enrollment and disenrollment of the covered population.

   1.4 Provider shall meet all applicable licensure, certification, and registration standards established by ADES/DDD and AHCCCS and as amended from time to time. Provider shall comply with all applicable DES/DDD and AHCCCS administrative rules, policies, procedures, service standards and guidelines which are hereby incorporated by reference into the Agreement. Policies and guidelines for DDD may be located on the DDD website at www.azdes.gov/ddd and policies and

guidelines for AHCCCS may be located on the AHCCCS website at www.azahcccs.gov.

1.5 Provider providing services to DDD under the Agreement shall do so in accordance with 42 C.F.R. §434.6(b), applicable AHCCCS rules and applicable provisions of Federal law and regulations, except for those requirements.

1.6 Providers shall adhere to the requirements outlined in AdSS Medical Policy Manual, Chapter 600.

1.7 **Transfer of Care**. When a PCP has initiated medication management services for a member to treat a behavioral health disorder, and it is subsequently determined by the PCP or Company that the member should be transferred to a T/RBHA/ behavioral health provider for evaluation and/or continued medication management services, the PCP shall coordinate the transfer of care and shall ensure continuity of care for these members.

1.8 **Standards for Managing Behaviors**. Providers must comply, to the extent applicable, with the requirements of A.A.C. R6-6-901 through R6-6-910, as amended, including the use and restrictions of behavioral intervention techniques, behavior modifying medications, emergency measures, and training, as well as the development, monitoring and approval process for a behavior plan.

2. **Nursing Facility Providers.**

2.1 Nursing facility providers must refund any payment received from a resident or family member (in excess of share of cost), for the period of time from the effective date of Medicaid eligibility.

2.2 Nursing facility providers shall ensure temporary nursing care registry personnel, including Nurse Aides, are properly certified and licensed before caring for members, in accordance with 42 CFR 483.75(e)(3) and 42 CFR 483.75(g)(2). Nursing facility providers must also ensure these registry personnel are fingerprinted as required by A.R.S. § 36-411.

2.3 **HCBS Certification.** Providers providing Physical Therapy Services for the habilitative needs of members twenty-One (21) years of age and older must be HCBS certified by DES/DDD as required in A.A.C. R6-6-1501 through R6-6-1533

MEDICARE ADVANTAGE PRODUCT ADDENDUM

The terms of this Medicare Advantage Product Addendum ("Addendum") apply to Provider's participation in the Medicare Advantage Product as described below. All terms and conditions of the Agreement not in conflict with the terms and conditions set forth in this Addendum shall apply to this Addendum. In the event of a conflict between the terms of the Agreement and this Addendum, the terms of this Addendum shall apply. All terms not capitalized herein shall have the meanings ascribed to them in the Agreement. The term "Applicable Law" or "applicable law" as used in the Agreement shall include, as it relates to this Addendum, all applicable orders, directives, instructions, sub-regulatory guidance, and other requirements of any Official, including requirements for Medicare Advantage plans that pertain to participation as a First Tier or Downstream Entity in the Medicare Advantage Program.

1. **DESCRIPTION**. The Medicare Advantage Product includes the Medicare Advantage ("MA") plan(s) offered, administered and/or serviced by Company for Medicare beneficiaries in connection with a

contract with the Centers for Medicare and Medicaid Services ("CMS") pursuant to Part C of Title XVIII of the Social Security Act ("Company's Medicare Plans"). Nothing herein requires that Provider be included in or designated as a Participating Provider in all MA plan(s)/plan variations or network(s) or in any specific geographic location(s).

2. **PAYMENT**.

2.1. **Reimbursement.** Reimbursement under this Addendum shall be made in accordance with the applicable Service and Compensation Schedule in the Agreement. Provider acknowledges that payments made to Provider by Company are made in whole or in part with Federal funds and subject Provider to those laws applicable to individuals/entities receiving Federal funds. [45 C.F.R. part 84 and 45 C.F.R. part 91].

2.2. **Prompt Pay**. In accordance with 42 C.F.R. § 422.520(b)(1), Company shall pay clean claims submitted by Provider for Covered Services provided to Medicare Members within thirty (30) calendar days of receipt. For purposes of this Addendum, the term "clean claim" shall have the meaning assigned in 42 C.F.R. §422.500.

2.3. **Overpayments.** Company shall have the right to pursue overpayments from Provider within three (3) years from the claim adjudication date.

2.4. **Medicare Payment Adjustment.** Company shall not pay any amounts beyond the amounts set forth in the applicable Service & Compensation Schedule, including but not limited to any incentive payments that may be payable under traditional Medicare, except as expressly required by the Agreement or Applicable Law. Further, the Parties acknowledge and agree that payments under the Medicare program to providers, suppliers, and Medicare Advantage organizations may be adjusted as the result of legislation, regulation, executive order or other federal mandate ("Medicare Payment Adjustment"). Furthermore, any such Medicare Payment Adjustment could result in an increase or decrease in Medicare payments. In accordance with the terms of this Agreement, the Parties agree that, in the event of a Medicare Payment Adjustment, Company's payment to Provider will be adjusted in accordance with the Medicare Payment Adjustment. Company shall adjust payments under this Agreement for Covered Services rendered by Provider on and after the effective date of the Medicare Payment Adjustment, and shall continue to adjust payments to Provider until the earlier of the date (i) the Medicare Payment Adjustment is discontinued or (ii) is replaced by a subsequent Medicare Payment Adjustment. Medicare Payment Adjustments do not include performance based incentive payments made under traditional Medicare as the result of the Medicare Access and CHIP Reauthorization Act of 2015 ("MACRA") and its implementing regulations, as may be amended from time to time.

3. **ASSIGNMENT.** Provider may not assign this Agreement without Company's prior written consent. Company may assign this Agreement, in whole or in part, from time to time. To support a partial assignment, Company may duplicate this Addendum, along with the underlying Agreement and any Service and Compensation Schedules applicable to participation in Company's Medicare Plans, and assign the duplicate while retaining all or part of the original. If Company sells all or a portion of Company's Medicare Plans, Company may also create and assign to the purchaser a duplicate of this Addendum along with the underlying Agreement and any Service and Compensation Schedules applicable to participation in Company's Medicare Plans. If Company assigns this Agreement to any entity other than an Affiliate, Company will provide advance written notice to Provider.

4. **SUBCONTRACTING.** Provider shall require all of its subcontractors, if any, to comply with Applicable Law.

4.1. **Contract Requirements**. Provider shall include in Provider's contracts with subcontractors all contractual and legal obligations required to appear in such contracts under Applicable Law. To the extent CMS requires additional provisions to be included in such subcontracts, Provider shall amend its contracts accordingly.

4.2. **Delegation.** If Provider delegates to a subcontractor a service required by this Agreement, and the service is required under the terms of Company's CMS Contract, Provider's subcontract shall be in writing and shall specify the delegated activities and reporting responsibilities, in addition to meeting the requirements described above. In the event that Company delegates a function to Provider, Company retains the right to approve, suspend or terminate such delegation.

5. **COMPLIANCE OBLIGATIONS**

5.1. **Compliance with CMS Contract, Law.** Any services performed by Provider for Company's Medicare Plans shall be consistent with Company's obligations under its CMS Contract and comply with Applicable Law. [42 C.F.R. § 422.504(i)(3)(iii)] and [42 C.F.R. § 423.505(i)(3)(iii)] [42 C.F.R. §§ 422.504(i)(4)(v)] and [42 C.F.R. § 423.505(i)(4)(iv)].

5.2. **Compliance with Medicare Policies.** In addition to complying with the obligations set forth in the underlying Agreement, Provider shall comply with Policies applicable to Company's Medicare Plans, including, but not limited, those contained in the Provider Manual, as modified by Company from time to time. Provider understands that Policy changes will automatically take effect on the date specified, unless an earlier date is required by Applicable Law. Provider is encouraged to contact Company to discuss any questions or concerns with Company Policies or Policy changes. [42 C.F.R. § 422.503] and [42 C.F.R. § 422.504] and [Medicare Managed Care Manual, Chapter 11, Section 100.4].

5.3. **Grievances/Appeals**. Provider agrees to cooperate with Company in resolving Medicare complaints, appeals, and grievances in accordance with Applicable Law. [42 C.F.R. § 422.504(a)(7)].

5.4. **Offshore Services**. Company adheres to its affiliated Arizona Medicaid MCO's policies regarding offshoring as D-SNP services are provided in coordination with that Medicaid MCO or other Arizona Medicaid MCO's. Please refer to Medicaid program requirements for offshoring services within the Medicaid Required Language above, including the incorporated AHCCCS Minimum Subcontract Provisions.

5.5. **Excluded Entities.** Provider agrees that no person or entity that provides services, directly or indirectly, for Company's Medicare Plans, may be an Excluded Entity under Section 1128 or 1128A of the Social Security Act. Provider shall screen the Exclusion Lists prior to initially hiring/contracting and monthly thereafter to ensure no employee or subcontractor appears on Exclusion Lists. If any employee or subcontractor appears on an Exclusion List or is otherwise prohibited from receiving payment under the Medicare program by Federal law, Provider will remove such individual or entity from any direct or indirect work on Company's Medicare Plans and promptly notify Company of the same.

5.6. **Compliance Program and Anti-Fraud Initiatives**. Provider shall maintain an effective compliance program to prevent, detect, and correct: (1) non-compliance with CMS's program requirements and (2) fraud waste and abuse ("FWA"). Such compliance program shall include dissemination to employees and Downstream Entities of (a) written policies and/or standards of conduct articulating the entity's commitment to compliance with Applicable Law, initially within ninety (90) days of hire/contracting, and at least annually thereafter; (b) communications regarding

the obligation to report potential non-compliance or FWA issues (internally and to payers, including Company, as applicable), and a no-tolerance policy for retaliation or retribution for good faith reporting, and reporting mechanisms to employees and Downstream Entities and (c) appropriate training and education to ensure familiarity with and compliance with the compliance program. Provider, through its compliance program, shall establish and maintain a process to: oversee and ensure that employees and Downstream Entities perform applicable services for Company's Medicare Plans consistent with this Agreement and Applicable Law and shall require implementation of disciplinary actions and corrective actions up to terminations where needed to ensure such compliance. Provider shall require that any Downstream Entity maintains an effective compliance program consistent with the requirements of this section. [42 C.F.R. §§ 422.504(i)(2)(i) and (iv)] and [42 C.F.R. §423.505].

5.7. **Home Infusion Drugs.** If Provider dispenses home infusion drugs that are covered under Medicare Part D to a Medicare Member and such Medicare Member has MA-PD coverage offered by Company ("Home Infusion Drug") then Provider agrees that the home infusion drugs section in the Provider Manual shall, as required by Applicable Law, be considered a part of this Agreement.

5.8. **Marketing.** Provider shall comply with the Medicare Communications and Marketing Guidelines ("MCMGs") and shall remain neutral when assisting Medicare beneficiaries with enrollment decisions. [Medicare Communications and Marketing Guidelines, as may be updated from time to time].

5.9. **Provider Directory.** Provider shall promptly provide Company with notice of any changes in Provider information set forth in Company's provider directory, including Provider's ability to accept new patients, the closing of a Provider's panel, the retirement or a provider leaving the group, or other similar changes at least thirty (30) days prior to the effective date of the change or no later than 10 days after such event. Provider shall respond to requests from Company for updated directory information within ten (10) calendar days of receipt of such request. [42 CFR §422.111(b)(3)] and [Medicare Managed Care Manual, Chpt. 4, § 110.2].

6. **MEDICARE MEMBER PROTECTIONS.**

6.1. **Hold Harmless.** Provider shall not hold Medicare Members liable for payment of any fees that are the legal obligation of the MA organization. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)]

6.2. **Continuation of Benefits**. If Company's CMS Contract terminates or Company becomes insolvent or fails to make payment under this Agreement, Provider shall continue to provide Covered Services to Medicare Members who are hospitalized through the date of discharge and shall be prohibited from billing Medicare Members for such Covered Services. [42 C.F.R. § 422.504(g)(2)(i) and (ii)].

6.3. **Non-Covered Services.** Provider must hold Medicare Members harmless for the cost of non-covered services, except for normal cost-sharing amounts (i.e., copayments, coinsurance, and/or deductibles), unless the Medicare Member has received a pre-service organization determination notice of denial from Company before such services are rendered by Provider. This restriction on holding a Medicare Member financially responsible for non-covered services does not apply in instances where a service is never covered by Medicare under any circumstance. [CMS, Memorandum to Medicare Advantage Plans, et. al, "Improper Use of Advance Notices of Non-coverage" (May 5, 2014).] [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)] and [42 C.F.R. §423.505(i)(3)(i)].

6.4. **Dual Eligible Cost Share**. Provider shall not hold Medicare Members eligible for both Medicare and Medicaid liable for Medicare Part A and B cost sharing when the State is responsible for paying

such amounts. Provider shall not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under title XIX if the individual were not enrolled in such a plan. Provider will: (1) accept Company's payment as payment in full, or (2) bill the appropriate State source. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(iii)].

7. **RECORDS AND AUDIT.**

7.1. **Maintenance of Records**. Provider shall preserve records applicable to Medicare Members and to Company's Medicare Plans, including its compliance with Applicable Law and this Agreement for the longer of: (i) the period of time required by State and Federal law, or (ii) ten (10) years. In addition, to the extent applicable, Provider shall comply with 42 C.F.R. §422.2480(c) and maintain all records containing data used by Company to calculate Medicare medical loss ratios ("MLRs") for Company's Medicare Plans and/or evidence needed by Company and/or Officials to validate MLRs (collectively, "MLR Records") for ten years from the year in which such MLRs are filed by Company.

7.2. **Audit.** Provider agrees that Officials, including but not limited to HHS, the Comptroller General, or their designees have the right to directly or indirectly audit, evaluate, and inspect—any pertinent information possessed by Provider or its Downstream Entities and relating to Company's Medicare Plans and any CMS Contract for any particular contract period, including, but not limited to, any books, contracts, computer or other electronic systems (including medical records and documentation of First Tier and Downstream Entities) (collectively, "Records") through 10 years from the final date of the Final Contract Period of the CMS Contract or from the date of Completion of Audit, whichever is later. Provider shall notify Company within two (2) business days of any request by an Official, or their designees, to audit or evaluate Provider Records, and to the extent feasible, shall provide Company the right to participate in any such evaluation of Provider. [42 C.F.R. §§ 422.504(i)(2)(i), (ii), and (iv)] and [42 C.F.R. § 423.505(i)(2)(i), (ii), and (iv)].

7.3. **Confidentiality and Accuracy of Records**. Provider will comply with the confidentiality and Medicare Member record accuracy requirements, including: (1) abiding by all Federal and State laws regarding confidentiality and disclosure of medical records, or other health and enrollment information, (2) ensuring that medical information is released only in accordance with Applicable Law, or pursuant to valid court orders or subpoenas, (3) maintaining the records and information in an accurate and timely manner, and (4) ensuring timely access by Medicare Members to the records and information that pertain to them. [42 C.F.R. §§ 422.504(a)(13) and 422.118] and [42 CFR § 423.136].

7.4. **Submission and Certification of Encounter Data**. Provider acknowledges that Company is required to provide CMS, other Officials and accrediting organizations with encounter data, including medical records and claims data. Provider shall routinely provide such encounter data to Company in the form and manner requested by Company. Provider certifies that such encounter data shall be accurate, complete and truthful to the best of its knowledge and belief. Provider agrees to immediately notify Company if any encounter data that Provider submitted to Company for Medicare Members is inaccurate, incomplete or erroneous, and cooperate with Company to correct erroneous encounter data.

7.5. **Company Oversight/Information and Records.** Provider acknowledges and agrees that Company shall monitor, shall have the right to audit, and remains accountable for, the functions and responsibilities performed by Provider for Company's Medicare Plans. Accordingly, in addition to specific requirements for information and records set forth in this Addendum, Provider agrees to promptly provide to Company any information and records, including without limit, MLR Records, if applicable, and information and records that are reasonably needed by Company: (1) for

administration of Company's Medicare Plans, (2) to monitor and audit performance of Provider and its subcontractors with this Agreement, Applicable Law, and requirements of accreditation agencies, including information regarding Provider's oversight and monitoring of its Downstream Entities (including a summary of any results of such activities), and (3) to fulfill any reporting requirements Company may have to CMS or other Officials, including information about any physician incentive plan that Provider may have relating to this Agreement. Provider shall complete an attestation from Company to confirm its compliance with requirements of this Agreement as it relates to Company's Medicare Plans upon request and agrees that Company may require corrective actions in the event of non-compliance. Ultimately, should Company determine such noncompliance has not been or is not capable of being corrected to Company's satisfaction, Company may terminate Provider's participation in Company's Medicare Plans in accordance with the terms of the Agreement.

8. **TERMINATION.** This Addendum may be terminated on its own without respect to the remainder of the Agreement, with or without cause, by either Party in accordance with the termination provisions of the underlying Agreement, except that no termination of this Medicare Addendum shall occur without cause or for convenience with less than 90 days advance notice to the other party. This Addendum shall terminate automatically in the event that the underlying Agreement is terminated in accordance with the termination provisions of the Agreement.

9. **DEFINITIONS:**

9.1. **CMS Contract**: The contract(s) with CMS governing Company's Medicare Plans.
9.2. **Completion of Audit:** Completion of audit by the Department of Health and Human Services, the Government Accountability Office, or their designees of Company or of any First Tier, Downstream, or Related Entity.
9.3. **Downstream Entity:** Any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with Company's Medicare Plans, below the level of the arrangement between an MA organization and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
9.4. **Excluded Entity:** A person or entity listed on the Department of Health and Human Services ("HHS") Office of Inspector General ("OIG") List of Excluded Individuals and Entities and the General Services Administration System for Awards Management ("SAM"), or appearing on the Federal Preclusion List.
9.5. **Exclusion Lists:** Collectively, the HHS OIG List of Excluded Individuals and Entities and the SAM.
9.6. **Final Contract Period:** The final term of the applicable CMS Contract governing Company's Medicare Plan(s).
9.7. **First Tier Entity:** Any party that enters into a written arrangement, acceptable to CMS, with an MA organization to provide administrative services or health care services for Medicare Members.
9.8. **Medicare Member:** A Medicare Advantage eligible individual who has enrolled in a Company Medicare Plan.
9.9. **Officials:** Federal and state regulatory agencies or officials with jurisdiction, including but not limited to CMS, HHS, the Comptroller General and their designees
9.10. **Offshore:** Physically located outside of one of the fifty United States or one of the United States Territories (i.e., American Samoa, Guam, Northern Marianas, Puerto Rico, and Virgin Islands)
9.11. **Policies:** Company's policies and procedures that relate to this Agreement, including, but not limited to, participation criteria; Provider Manuals; clinical policy bulletins; credentialing/recredentialing, utilization management, quality management, audit, coordination of benefits, complaint and appeals, and other policies and procedures (as modified from time to time), that are made available to Provider electronically or through other commonly accepted media. This includes but is not specifically limited to Medicare Policies.

9.12. **Provider Manual:** Company's handbook(s), manual(s) and guide(s) applicable to various types of Participating Providers, including but not limited to Medicare specific content.

FAMILY PLANNING BENEFITS

Notwithstanding any other provision of the Agreement, and exclusively with respect to Family Planning services rendered by Provider pursuant to the Agreement, any reference in the Agreement or Company's policies and procedures to "Mercy Care" or to "Mercy Care Advantage" shall be replaced with "Plan Administrator" for purposes of: (i) performing obligations or enforcing rights directly connected to the administration of Family Planning services; (ii) exchanging any payment, correspondence, information (including without limitation Encounter Data and claims data) or reports between Company and Provider.

"Plan Administrator" shall mean Aetna Medicaid Administrators, LLC, or such other entity designated by Company and identified to Provider in writing. Notices and other correspondence submitted to Plan Administrator under the Agreement shall be sent to the following address:

Aetna Medicaid Administrators, LLC
Attention: Legal Department
4500 E. Cotton Center Blvd.
Phoenix, Arizona 85040

With copy to:

Mercy Care
Attention: Network Development
4755 S. 44th Place
Phoenix, AZ 85040

For purposes of the Agreement, Family Planning services shall mean those services in accordance with the AHCCCS Medical Policy Manual for all members (male and female) who choose to delay or prevent pregnancy. These include medical, surgical, pharmacological and laboratory services, as well as contraceptive devices. Information and counseling, which allow members to make informed decisions regarding family planning methods, shall also be included.

[End of Document]