Arizona Regulatory Compliance Addendum
Medicare Advantage Product

The terms of this Arizona Regulatory Compliance Addendum - Medicare Advantage Product ("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**.

   A. **Reimbursement.** Reimbursement under this Addendum shall be made in accordance with the applicable Service and Rate 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].

   B. **Prompt Pay**. 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. Company shall pay Provider as set forth in the applicable Service and Rate Schedule in the Agreement and in accordance with 42 CFR § 422.520(b).

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

   D. **Medicare Payment Adjustment.** Company shall not pay any amounts beyond the amounts set forth in the applicable Service and Rate 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 Rate 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 Rate 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.

A. **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.

B. **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. If Company delegates a function to Provider, Company retains the right to approve, suspend or terminate such delegation. In addition, Provider shall prohibit its subcontractors from further subcontracting or delegating services required under the terms of Company's CMS Contract without prior written consent from Company.

5. **COMPLIANCE OBLIGATIONS**

A. **Compliance with CMS Contract, Law.** Any services performed by Provider or its subcontractors 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)].

B. **Compliance with Medicare Policies** 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].

C. **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)].

D. **Offshore Services.** Provider delivers services to, or related to, members who are enrolled in the Dual Eligible Special Needs Plan (DSNP) covered by this agreement. Accordingly, Provider agrees to comply with applicable Company policy, regulation, statute, or the State Medicaid Agency Contract (SMAC) with Company with regards to handling of certain information and data as it relates to offshore services.

E. **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.

F. **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].

G. **Home Infusion Drugs.** If Provider dispenses home infusion drugs that are covered under both Medicare Part B and 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. If Provider dispenses Home Infusion Drugs to a Medicare Member that are covered under the Medicare Member's Plan, then Provider agrees that the Home Infusion Drug provisions in the Provider Manual shall, as required by Applicable Law, be considered a part of this Addendum.

H. **Marketing.** Provider shall comply with the Medicare Communications and Marketing Guidelines ("MCMGs") as codified in 42 CFR 422.2260-422.2266 and 422.2274 and 423.2260-422.2266 and 423.2274 and shall remain neutral when assisting Medicare beneficiaries with enrollment decisions.

I. **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.

A. **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)].

B. **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)].

C. **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)].

D. **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.

A. **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.

B. **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 make best efforts to 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)].

C. **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].

D. **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. Provider acknowledges its coding of claims and documentation to support such is relied on by CMS for audits and payment calculations. Provider shall routinely provide education and oversight to its staff that support coding and documentation and for its third-party billers, as applicable, on coding and documentation. As applicable, Provider agrees to participate in Company's training and education on coding, from time to time. In the alternative, Provider may provide similar coding and documentation training and certify such to Company provided the training complies with CMS and other required coding guidance. If there are issues or patterns and practice that need to be corrected as determined by audits, including those by CMS such as for RADV audits, OIG audits, Company audits or audits by other governmental regulators, Provider agrees to fully cooperate and comply with Company's recommendations including completing any corrective action plans, participating in training and education or offering its own training and education as well as correcting its coding, claims and documentation.

E. **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 with the requirements of this Agreement. 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.

DEFINITIONS:

A. **CMS Contract:** The contract(s) with CMS governing Company's Medicare Plans.

B. **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.

C. **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.

D. **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.

E. **Exclusion Lists:** Collectively, the HHS OIG List of Excluded Individuals and Entities and the SAM.

F. **Final Contract Period:** The final term of the applicable CMS Contract governing Company's Medicare Plan(s).

G. **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.

H. **Medicare Member:** A Medicare Advantage eligible individual who has enrolled in a Company Medicare Plan.

I. **Officials:** Federal and state regulatory agencies or officials with jurisdiction, including but not limited to CMS, HHS, the Comptroller General and their designees

J. **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.

K. **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
4750 S. 44th Place, Suite 150
Phoenix, Arizona 85040

With copy to:

Mercy Care Advantage
Attention: Network Management
4750 S. 44th Place, Suite 150
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 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.