MEDICARE ADVANTAGE
MEDICARE/MEDICAID DUAL ELIGIBLE

ADDENDUM

Medicare Advantage/Medicare-Medicaid Required Provisions

The Plan has a contract with CMS for the provision of services to Medicare Enrollees. Accordingly, Practitioner agrees to provide all services under the Agreement in compliance with the following provisions.

Definitions:

Centers for Medicare and Medicaid Services ("CMS"): the agency within the Department of Health and Human Services that administers the Medicare program.

Completion of Audit: completion of audit by the Department of Health and Human Services, the Government Accountability Office, or their designees of a Medicare Advantage Organization, Medicare Advantage Organization contractor or related entity.

Downstream Entity: any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the Medicare Advantage benefit, below the level of the arrangement between an Medicare Advantage organization (or applicant) and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

Final Contract Period: the final term of the contract between CMS and the Medicare Advantage Organization.

First Tier Entity: any party that enters into a written arrangement, acceptable to CMS, with an Medicare Advantage organization or applicant to provide administrative services or health care services for a Medicare eligible individual under the Medicare Advantage program.

Medicare Advantage ("MA"): an alternative to the traditional Medicare program in which private plans run by health insurance companies provide health care benefits that eligible beneficiaries would otherwise receive directly from the Medicare program.

Medicare Advantage Organization ("MA organization"): a public or private entity organized and licensed by a State as a risk-bearing entity (with the exception of provider-sponsored organizations receiving waivers) that is certified by CMS as meeting the Medicare Advantage contract requirements.

Member or Enrollee: a Medicare Advantage eligible individual who has enrolled in or elected coverage through a Medicare Advantage Organization.

Provider: (1) any individual who is engaged in the delivery of health care services in a State and is licensed or certified by the State to engage in that activity in the State; and (2) any entity that is engaged in the delivery of health care services in a State and is licensed or certified to deliver those services if such licensing or certification is required by State law or regulation.

Related entity: any entity that is related to the Medicare Advantage organization by common ownership or control and (1) performs some of the Medicare Advantage organization's management functions under contract or delegation; (2) furnishes services to Medicare enrollees under an oral or written agreement; or (3) leases real property or sells materials to the Medicare Advantage organization at a cost of more than $2,500 during a contract period.

Required Provisions:

Practitioner agrees to the following:

1. HHS, the Comptroller General or their designees have the right to audit, evaluate and inspect any pertinent information for any particular contract period, including, but not limited to, any books, contracts, computer or other electronic systems (including medical records and documentation of the first tier, downstream and entities related to CMS' contract with Plan (hereinafter, "MA organization") through 10 years from the final date of the final contract period of the contract entered into between CMS and the MA organization or from the date of completion of any audit, whichever is later. [42 C.F.R. §§ 422.504(i)(2)(i) and (ii)]

2. Practitioner will comply with the confidentiality and enrollee 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 Federal or State law, or pursuant to court orders or subpoenas; (3) maintaining the records and information in an accurate and timely manner; and (4) ensuring timely access by enrollees to the records and information that pertain to them. [42 C.F.R. §§ 422.504(a)(13) and 422.118]

3. Enrollees will not be held 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)]

4. For all enrollees eligible for both Medicare and Medicaid, enrollees will not be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts. Providers will be informed of Medicare and Medicaid benefits and rules for enrollees eligible for Medicare and Medicaid. Practitioner may 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. Providers will: (1) accept the MA plan 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)(i)]

5. Any services or other activity performed in accordance with a contract or written agreement by Practitioner are consistent and comply with the MA organization's contractual obligations. [42 C.F.R. § 422.504(i)(3)(iii)]

6. Contracts or other written agreements between the MA organization and providers or between first tier and downstream entities must contain a prompt payment provision, the terms of which are developed and agreed to by the contracting parties. The MA organization is obligated to pay contracted providers under the terms of the contract between the Practitioner and the Provider. [42 C.F.R. §§ 422.520(b)(1) and (2)]

7. Practitioner and any related entity, contractor or subcontractor will comply with all applicable Medicare laws, regulations and CMS instructions. [42 C.F.R. §§ 422.504(i)(4)(v)]

8. If any of the MA organization's activities or responsibilities under its contract with CMS are delegated to any first tier, downstream and related entity:

   i. The delegated activities and reporting responsibilities are specified in writing**.**

   ii. CMS and the MA organization reserve the right to revoke the delegation activities and reporting requirements or to specify other remedies in instances where CMS or the MA organization determine that such parties have not performed satisfactorily.

   iii. The MA organization will monitor the performance of the parties on an ongoing basis.

   iv. The credentials of medical professionals affiliated with the party or parties will be either reviewed by the MA organization or the credentialing process will be reviewed and approved by the MA organization and the MA organization must audit the credentialing process on an ongoing basis.

   v. If the MA organization delegates the selection of providers, contractors or subcontractor, the MA organization retains the right to approve, suspend or terminate any such arrangement. [42 C.F.R. §§ 422.504(i)(4) and (5)].

In the event of a conflict between the terms and conditions above and the terms of a related agreement, the terms above control.

Medicare-Medicaid Program Required Provisions

The Plan has a contract with CMS for the provision of services under the Medicare-Medicaid ("MMP") Program. Accordingly, Practitioner agrees to provide all services under the Agreement in compliance with the following provisions.

1. HHS, the Comptroller General or their designees have the right to audit, evaluate and inspect any pertinent information of Practitioner including books, contracts, records, including medical records, and documentation related to CMS' contract with the Plan for a period of 10 years from the final date of the contract period or the completion of any audit, whichever is later. §422.504(i)(2)(i) and (ii).

2. Where applicable, Practitioner providers and suppliers agree to safeguard beneficiary privacy and confidentiality of beneficiary health records. §422.504(a)13.

3. Where applicable, Practitioner may not hold beneficiaries liable for payment of fees that are the legal obligation of the Plan. §422.504(g)(1)(i); §422.504(i)(3)(i).

4. Any services performed will be consistent and comply with the Plan's contractual obligations with CMS and New York State Department of Health. §422.504(i)(3)(iii).

5. The Plan retains the right to approve, suspend or terminate such arrangement. §422.504(i)(5).

6. All delegated activities and reporting responsibilities of Practitioner are clearly defined in this Agreement. §422.504(i)(4)(i).

7. The Plan may revoke any of the delegated activities and reporting requirements or specify other remedies in instances when CMS or the New York State Department of Health determines that the parties to this Agreement have not performed satisfactorily. §422.504(i)(3)(ii); §422.504(i)(4)(ii).

8. Performance of the parties is monitored by the Plan on an ongoing basis. §422.504(i)(3)(ii); §422.504(i)(4)(iii).

9. The credentials of medical professionals affiliated with the parties will either be reviewed by the Plan or the credentialing process will be reviewed and approved by the Plan; and the Plan must audit the credentialing process on an ongoing basis. §422.504(i)(4)(iv)(A)(B).

10. Practitioner must comply with all applicable Medicare laws, regulations and CMS instructions. §422.504(i)(4)(v).

11. This Agreement incorporates the Medicare-Medicaid population.

12. Practitioner will complete required FIDA training outlined in the New York State Memorandum of Understanding or certify to HIP or the Plan that training has been completed through another health plan or organization approved by CMS to provide such training. Training will include:

    i. No balance billing of FIDA participants.
    ii. Cultural and linguistic competency for delivering services to FIDA participants.
    iii. Physical accessibility, which is defined in accordance with US Department of Justice ADA guidance for providers.
    iv. Disability competency for delivering services to FIDA participants.

    Required training for Interdisciplinary Care Team Members (IDT) only:

    i. Person-centered planning process
    ii. Independent living and recovery
    iii. Wellness principles
    iv. Olmstead requirements
    v. Coordinating with behavioral health and community-based and facility-based long-term services and supports (LTSS) providers, providing information about accessing behavioral health and community-based and facility-based LTSS, and furnishing lists of community supports available.
    vi. How to identify behavioral health needs, how to assist the Participant in obtaining behavioral health services, how to identify community-based and facility-based LTSS needs, and how to assist the Participant in obtaining community-based and facility-based LTSS services (required only for primary care providers)

13. Practitioner agrees to use evidence-based practices specific to his/her/their area of practice.