

MEDICARE ADVANTAGE ADDENDUM

The following provisions apply to all Medicare Advantage Members:

1. Record Retention.

Provider shall give the U.S. Department of Health and Human Services (HHS) and U.S. General Accounting Office (GAO), and their authorized designees, the right to audit, evaluate and inspect books, contracts, records, including medical records, and other records of Provider relating to its participation in Plan's Medicare Advantage product(s) and to services furnished to Medicare Advantage Members, and any other relevant information that the Centers for Medicare and Medicaid Service (CMS) may require during the term of this Agreement and for a period of ten (10) years following termination or expiration of this Agreement for any reason, or until completion of an audit, whichever is later pursuant to 42 C.F.R. §422.504(i)(2)(ii), unless such time frame is extended pursuant to 42 C.F.R. § 422.504(e)(4) (such as in the event of fraud). This provision shall survive termination of the Agreement.

2. Privacy/Confidentiality.

Provider agrees to safeguard the privacy of information that identifies a particular Plan's Medicare Advantage Member in accordance with Federal and State laws; and maintain the Plan's Medicare Advantage Member's medical, health and enrollment records in an accurate and timely manner pursuant to 42 C.F.R. §422.118.

3. Hold Harmless.

As set forth in 42 C.F.R. §422.504(g)(1)(i), Provider shall ensure that in no event, including but not limited to, non-payment, Organization or Payor insolvency, or breach of this Agreement, will Provider bill, or hold any Medicare Advantage Member liable for payment of any such fees that are the legal obligation of Provider or Plan. This provision shall not prevent the collection of any applicable co-pays, coinsurance, or charges for non-covered services delivered to a Medicare Advantage Member. This provision shall survive termination of the Agreement.

4. Prompt Payment.

Plan and Provider agree to follow prompt pay regulations regarding clean claims payment within thirty (30) days according to arrangements set forth in the Agreement and Plan policy as outlined in the Provider Manual. (42.C.F.R. §422.520(b))

5. Delegation.

If Plan has delegated to Provider certain Medicare Advantage obligations, Provider and Plan shall, in accordance with 42 C.F.R. §422.504(i)(3)(iii) and 42 C.F.R. §422.504(i)(4), specify delegated activities and reporting responsibilities in a written document. The written document shall also identify revocation of delegation activities and reporting requirements or specify other such remedies in instances where CMS or Plan determines that Provider has not performed satisfactorily. Plan shall monitor the performance of Provider and if delegated, audit the credentialing process on an ongoing basis when deemed appropriate by Plan. Plan retains the right to approve, suspend, or terminate any individual provider selected or credentialed by Provider as set forth in 42 C.F.R. §422.504(i)(5).

6. Compliance with Medicare Advantage Program Policies and Procedures.

Provider will comply with all Medicare Advantage Program policies and procedures as outlined in the Provider Manual and will ensure that services performed will be consistent and comply with said policies and procedures as set forth in 42 C.F.R. 422.504(i)(4)(v).

7. Compliance with Federal, State, and Medicare Laws.

Provider agrees to comply, and to ensure that contracted providers comply, with laws applicable to individuals and entities receiving Federal funds as well as all other applicable State and Federal laws and regulations, including but not limited to those governing participation in the MA Program, pursuant to 42 C.F.R. §422.504(h) and 42 C.F.R. §422.504(i)(4)(v). Provider further agrees to incorporate into this contract such other terms and conditions as CMS may find necessary and appropriate, including amendments to CMS rules, regulations and guidance.

8. Fraud, Waste and Abuse.

Provider agrees to comply with applicable federal laws and regulations designed to prevent fraud, waste, and abuse, including, but not limited to, applicable provisions of federal criminal law, the False Claims Act, the anti-kickback statute; and the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) administrative simplification rules, as may be amended from time to time. Further, Provider shall have a compliance plan in force to include, but not be limited to: (1) measures to prevent, detect and report fraud, waste, and abuse; and (2) written policies, procedures, and standards of conduct that address Provider’s commitment to comply with all applicable Federal and State guidelines relating to the prevention and reporting of fraud, waste and abuse. Provider is responsible for training and educating his/her staff on an annual basis. Such compliance training shall include but not be limited to procedures for effective internal monitoring and auditing. Provider shall allow Avesis to maintain oversight of Provider’s training efforts under its compliance plan and Avesis shall provide training materials, as necessary, to Provider, upon request.

9. Anti-Kickback Statute

Payments made to Provider for the treatment of a member in a Medicare Advantage plan are made, in whole or in part, from Federal funds, and subject Provider to all laws applicable to the individuals or entities who receive Federal funds, including the False Claims Act (32 USC 3729, et. seq.), the Anti-Kickback Statute (section 1128B(b) of the Social Security Act), Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act, and the Rehabilitation Act of 1973.

10. Accountability.

In accordance with 42 C.F.R. §422.504(i)(3)(ii)(A), Plan is accountable to monitor Provider on an ongoing basis and is accountable to CMS for any functions or responsibilities that are described in these standards.