**SUBMITTAL TO THE BOARD OF SUPERVISORS**
**COUNTY OF RIVERSIDE, STATE OF CALIFORNIA**

919

**FROM:** Riverside County Regional Medical Center

**SUBMITTAL DATE:**
April 25, 2013

**SUBJECT:** Amendment to the Inland Empire Health Plan Hospital Per Diem Agreement

**RECOMMENDED MOTION:** Move that the Board of Supervisors:

1) Ratify the tenth amendment to the Inland Empire Health Plan Hospital Per Diem Agreement effective April 1, 2013; and
2) Authorize the Chairperson to sign three (3) copies of the amendment; and
3) Direct the Clerk of the Board to return all three (3) copies of the signed originals to Riverside County Regional Medical Center Administration. Upon final execution by the Inland Empire Health Plan Governing Board, a fully executed agreement will be returned to the Clerk of the Board.
4) Direct the Clerk of the Board to hold this Agreement as a confidential document, not subject

(continued on Page 2)

Douglas D. Bagley

Douglas D. Bagley, Hospital Director

| FINANCIAL DATA | | | | |
|---|---|---|---|---|
| | Current F.Y. Total Cost: | $ 0 | In Current Year Budget: | Yes |
| | Current F.Y. Net County Cost: | $ N/A | Budget Adjustment: | No |
| | Annual Net County Cost: | $ 0 | For Fiscal Year: | 2012/2013 |

**SOURCE OF FUNDS:** Revenue from the Inland Empire Health Plan HMO Members referred to hospital for services

| | |
|---|---|
| Positions To Be Deleted Per A-30 | ☐ |
| Requires 4/5 Vote | ☐ |

**C.E.O. RECOMMENDATION:**

APPROVE

BY: Debra Cournoyer

Debra Cournoyer

**County Executive Office Signature**

FORM APPROVED COUNTY COUNSEL
BY: NEAL R. KIPNIS DATE 4/4/13

Departmental Concurrence

☒ Policy ☐ Consent

☐ Policy ☐ Consent

Dep't Recomm.:

Per Exec. Ofc.:

2013 JUN 18 AM 8:43

**Prev. Agn. Ref.:** 11/25/08 3.35; 9/1/09, 3.93; 11/24/09 3.92; 8/16/11 3.72, 4/24/12 3.17, 7/17/12 3.37 11/6/12 3.57 1/29/13 3.35 1/29/35 3.36

**District:** All

**Agenda Number:** 3-34

ATTACHMENTS FILED WITH THE CLERK OF THE BOARD

**SUBJECT:**

Amendment to the Inland Empire Health Plan Hospital Per Diem Agreement

to release under the Public Records Act, and Health and Safety Code Section, 1457 (C) (1).

**BACKGROUND:**

On June 19, 2007, agenda item no. 3.24 the Board of Supervisors approved a Hospital Per Diem Agreement with Inland Empire Health Plan (IEHP) for a term of five (5) years that ended on March 1, 2012. This amendment, effective April 1, 2013 thru March 30, 2014, increases the payment rate for inpatient and outpatient health care services based on the level of acuity or type of service provided to IEHP Managed Care Medi-Cal, Healthy Families and Healthy Kids enrollees seen at Riverside County Regional Medical Center. A separate hospital services agreement will be negotiated for the 2014 Medicaid Expansion Population. Compensation rates for the IEHP Medicare Advantage program have also been incorporated into this amendment under Attachment C.

**REVIEW/APPROVAL:**
County Counsel has approved the agreement as to legal form.

DB:cg

TENTH AMENDMENT

TO THE HOSPITAL PER DIEM AGREEMENT

BETWEEN

INLAND EMPIRE HEALTH PLAN AND IEHP HEALTH ACCESS

AND

RIVERSIDE COUNTY REGIONAL MEDICAL CENTER

WHEREAS, the Inland Empire Health Plan ("IEHP"), IEHP Health Access ("Health Access"), through its management agreement with Inland Empire Health Plan (Inland Empire Health Plan and "Health Access" are known collectively as "IEHP Health Plan"), and Riverside County Regional Medical Center ("HOSPITAL") agree to further amend the Hospital Per Diem Agreement, as amended, between them dated, April 1, 2007;

NOW THEREFORE, the parties agree as follows:

A. The language on Section 9.01, TERM, is hereby amended to add the following language at the end of the existing section, as amended:

9.01 TERM – "The term of this Agreement shall commence on April 1, 2013, and shall continue for one (1) year terminating on March 31, 2014, unless sooner terminated in accordance with the terms and conditions of this Agreement herein."

B. The language of ATTACHMENT C, COMPENSATION RATES, is hereby deleted in its entirety and is replaced as attached hereto (see amended ATTACHMENT C, COMPENSATION RATES).

C. The definition of DUAL ELIGIBLE BENEFICIARY is hereby added as follows:

"DUAL ELIGIBLE BENEFICIARY – shall mean an individual 21 years of age or older who is enrolled for benefits under Medicare Part A (42 U.S.C. § 1395c *et seq.*) and Medicare Part B (42 U.S.C. § 1395j *et seq.*) and is eligible for medical assistance under the Medi-Cal State Plan."

D. The definition of MEDICARE is hereby added as follows:

"MEDICARE – A benefit package that offers a specific set of health benefits at a uniform premium and uniform level of cost-sharing to all people with Medicare who live in the service area covered by IEHP Health Plan as outlined in Attachment F. Medicare includes IEHP Health Plan's D-SNP product as well as the Capitated Financial Alignment Demonstration, also known as the "Duals Pilot Project," which is the pilot program seeking to integrate care across delivery systems for Dual Eligible Beneficiaries, as developed by CMS and DHCS."

E. Attachment F, INDIGENT PROGRAM, is hereby deleted in its entirety.

F. Attachment F, MEDICARE ADVANTAGE PROGRAM, is hereby attached to the Agreement in the same form as attached hereto.

G. Notwithstanding the date of execution, unless otherwise referenced, this Tenth Amendment shall be effective April 1, 2013.

H. All other terms and conditions of said Hospital Per Diem Agreement, as amended, are to remain in full force and effect.

I. HOSPITAL certifies that the individual signing herein has authority to execute this Amendment on behalf of HOSPITAL, and may legally bind HOSPITAL to the terms and conditions of this Amendment, and any attachments hereto.

(THE BALANCE OF THIS PAGE INTENIONALLY LEFT BLANK)

IN WITNESS WHEREOF, the parties hereto have signed this Amendment as set forth below.

**RIVERSIDE COUNTY REGIONAL MEDICAL CENTER**

By: _____

Name: Douglas D. Bagley

Title: Hospital Director - ICEO

Date: _____

By: 4/24/13
Chairperson, Board of Supervisors

Date: _____

Attest: _____

Date: _____

Approved as to Form:

Pamela J. Walls
County Counsel

By: _____

Date: 6/4/13

[Document continued on next page]

**IEHP HEALTH ACCESS**

By: _____
Bradley P. Gilbert, M.D.
Chief Executive Officer

Date: 5/7/13

By: _____
Chairperson
IEHP Health Access
Governing Board

Date: 5-13-13

Attest: _____
Secretary
Inland Empire Health Plan for
IEHP Health Access

Date: 5-13-13

Approved as to Form

PAMELA J. WALLS
County Counsel

By: _____
Deputy County Counsel
Attorneys for IEHP Health Access

Date: 5/13/13

**INLAND EMPIRE HEALTH PLAN**

By: _____
Bradley P. Gilbert, M.D.
Chief Executive Officer

Date: 5/7/13

By: _____
Chairperson
Inland Empire Health Plan
Governing Board

Date: 5-13-13

Attest: _____
Secretary
Inland Empire Health Plan

Date: 5-13-13

Approved as to Form

PAMELA J. WALLS
County Counsel

By: _____
Deputy County Counsel
Attorneys for Inland Empire Health Plan

Date: 5/13/13

## ATTACHMENT C

## COMPENSATION RATES

The following all-inclusive Rates shall be paid to HOSPITAL when IEHP HEALTH PLAN is the payor for authorized Hospital Services, including medical services and supplies provided to Members during the course of such visit or admission, pursuant to this Agreement. HOSPITAL shall accept such reimbursement, less applicable Member co-payment, as payment in full for those authorized Hospital Services provided to Members. Reimbursement shall not exceed billed charges. Revenue Codes, CPT, HCPCs, and ICD-9 Codes used in this document are for reference and clarification purposes only.

| INPATIENT HOSPITAL SERVICES: | Medi-Cal Per Diem Rate | Healthy Families, Healthy Kids |
|---|---|---|
| **Medical/Surgical/Pediatrics** (Rev. Codes 100, 101, 110, 111, 113, 117, 119, 120, 121,123, 127, 129, 130, 131, 133, 139, 140, 141, 143, 147, 149, 150, 151, 153, 157, 159, 160, 164, 167, 169) | $1,582 | $1,300 |
| **Definitive Observation/Telemetry** (Rev Code 206, 214) | $1,582 | $1,375 |
| ICU (Rev. Code 200,201,202,203,207,208, 209)<br>CCU (Rev. Code 210,211,212, 213, 214, 219) | $1,582 | $1,825 |
| **Acute Rehab Per Diem** (Rev. Code 190) | $800 | $950 |
| **Boarder Baby** (Rev. Code 170,179) | $375 | $500 |
| **Nursery Newborn Level 1** (Rev. 171) | $1,582 | $2,350 |
| **Nursery Newborn Level 2** (Rev. 172) | $1,582 | $2,350 |
| **Nursery Newborn Level 3** (Rev 173) | $1,582 | $2,350 |
| **Nursery Newborn Level 4** (Rev. 174, 175) | $1,582 | $2,350 |
| **OB Normal Delivery** (Rev. Code 112, 122, 132, 142, 152, ICD9 Codes 72.0-73.99) | $1,582 Per Diem | $2,100 Case Rate |
| **OB C-Section** (Rev. Code 112, 122, 132, 142, 152, ICD9 Codes 74.0-74.99) | $1,582 Per Diem | $4,000 Case Rate |
| **Additional OB Normal and C-Section Days** | LOC | LOC |
| Trauma Services (Rate valid for all days that the Trauma Team is actively providing Care; applicable LOC thereafter) | $2,500 | $3,150 |

| EMERGENCY ROOM (Rev Code 450, 451, 452, 456, 459)<br>(CPT Codes must be used below) | Medi-Cal | Healthy Families, Healthy Kids |
|---|---|---|

| | | |
|---|---|---|
| **Emergency HCFA Level I Case Rate (CPT Code 99281)** | **100% Med-Cal Fee Schedule for Hospitals** | **35% billed charges NTE $700** |
| **Emergency HCFA Level II Case Rate (CPT Code 99282)** | **100% Med-Cal Fee Schedule For Hospitals** | **35% billed charges NTE $700** |
| **Emergency HCFA Level III Case Rate (CPT Code 99283)** | **100% Med-Cal Fee Schedule For Hospitals** | **35% billed charges NTE $1,700** |
| **Emergency HCFA Level IV Case Rate (CPT Code 99284)** | **100% Med-Cal Fee Schedule For Hospitals** | **35% billed charges NTE $2,250** |
| **Emergency HCFA Level V Case Rate (CPT Code 99285)** | **100% Med-Cal Fee Schedule For Hospitals** | **35% billed charges NTE $2,250** |

| **OUTPATIENT SURGICAL SERVICES*:** | **Medi-Cal** | **Healthy Families, Healthy Kids** |
|---|---|---|
| **Outpatient Surgery** | **100% Med-Cal Fee Schedule For Hospitals** | **100% Medicare OPPS** |

| **OUTPATIENT DIAGNOSTIC AND THERAPEUTIC SERVICES:** | **Medi-Cal** | **Healthy Families, Healthy Kids** |
|---|---|---|
| Outpatient Laboratory **(Rev Codes 300, 301, 302, 303, 304, 305, 306, 307 921, 923, 925)** *CPT Codes must be used in billing* | **100% Med-Cal Fee Schedule for Hospitals** | **125% Medicare OPPS** |
| **Outpatient Pathology** (Rev Codes 310, 311, 312, 314) **CPT Codes must be used in billing** | **100% Med-Cal Fee Schedule for Hospitals** | **125% Medicare OPPS** |
| **Outpatient Magnetic Resonance Imaging** (includes contrast) (Rev Codes 610, 611, 612, 614, 615, 616, 618) | **100% Med-Cal Fee Schedule for Hospitals** | **125% Medicare OPPS** |
| **Outpatient Computerized Tomography** (includes contrast) (Rev Codes 350-352) | **100% Med-Cal Fee Schedule for Hospitals** | **125% Medicare OPPS** |
| **Ultrasound Imaging** (Rev Code 402) | **100% Med-Cal Fee Schedule for Hospitals** | **125% Medicare OPPS** |
| **Diagnostic and Screening Mammography** (Rev Code 401, 403) | **100% Med-Cal Fee Schedule for Hospitals** | **125% Medicare OPPS** |
| **Other Diagnostic Radiology** (Rev Codes 320-324) | **100% Med-Cal Fee Schedule for Hospitals** | **125% Medicare OPPS** |
| **Observation Case Rate (payable up to 23 hours and 59 minutes –includes OB Observation)** (Rev Codes 760, 762) | **100% Med-Cal Fee Schedule for Hospitals** | **$975** |

| | | |
|---|---|---|
| **Lithotripsy, CPT Codes 52353, 50590 (includes 3 attempts)** | **100% Med-Cal Fee Schedule for Hospitals** | **125% Medicare OPPS** |
| **All other Outpatient Services not listed above** | **100% Med-Cal Fee Schedule for Hospitals** | **125% Medicare OPPS** |

Exclusions: The following items are excluded from all Inpatient Hospital Services and shall be reimbursed if authorized as indicated.

- Implants and Prosthetics over $1,000.00 reimbursed at Invoice amount plus 5%. (Revenue Codes 274-278 exceeding $1,000.00 invoice cost per item)

**ATTACHMENT C**
**(Cont.)**

## COMPENSATION RATES – MEDICARE ADVANTAGE PROGRAM

## RIVERSIDE COUNTY REGIONAL MEDICAL CENTER

The following all inclusive rates shall be paid to Hospital when IEHP is the payor for authorized Hospital Services, including medical services and supplies provided to Members during the course of such visit or admission, pursuant to this Agreement. Hospital shall accept such reimbursement, less applicable Member co-payments, as payment in full for those authorized Hospital Services provided to members. Reimbursement shall not exceed billed charges.

| Services | Reimbursement |
|---|---|
| Inpatient Hospital Services, all inclusive | Applicable Hospital Medicare Diagnosis Related Group (DRG) |
| Outpatient Hospital Services | 100% of prevailing Medicare allowable as Updated annually by CMS |

Medicare Allowable shall be based upon the applicable Hospital's Medicare Inpatient and Outpatient Prospective Payment System (IPPS/OPPS) to include both operating and capital payment adjustments and all applicable add-on payment adjustments (e.g. outliers, disproportionate share and indirect medical education) and all applicable pass-through payments (e.g. direct medical education and organ acquisition cost).

## ATTACHMENT F

## MEDICARE ADVANTAGE PROGRAM

## RIVERSIDE COUNTY REGIONAL MEDICAL CENTER

## I. DEFINITIONS

For purposes of this Attachment, the following definitions shall apply. All regulatory references in the brackets are to sections contained in 42 CFR Part 422, unless otherwise indicated.

1.1. **Downstream Entity** means all entities or individuals below the level of the First Tier Entity (e.g., individual providers that contract with an IPA or Administrative Service Entities), typically referred to as subcontractors, related entities, and management companies. Downstream Entity shall also be referred to as a Provider.

1.2. **End Stage Renal Disease (ESRD)** means members who require kidney dialysis for the remainder of life.

1.3. **First Tier Entity** means the contracted provider, which is the first level of contractor with the Health Plan (e.g., Individual Practice Association (IPA), Hospital, Physician, Specialist, Ancillary Provider or Physician Hospital Association (PHO) who or which has a direct contract with Health Plan).

1.4. **Centers for Medicare and Medicaid Services (CMS)** means the agency within the Department of Health and Human Services that administers the Medicare Program.

1.5. **CMS Agreement** means the Medicare Advantage contract between CMS and the MAO.

1.6. **Dual Eligible Beneficiary** means an individual 21 years of age or older who is enrolled for benefits under Medicare Part A (42 U.S.C. § 1395c *et seq.*) and Medicare Part B (42 U.S.C. § 1395j *et seq.*) and is eligible for medical assistance under the Medi-Cal State Plan.

1.7. **Medicare** means a benefit package that offers a specific set of health benefits at a uniform premium and uniform level of cost-sharing to all people with Medicare who live in the service area covered by the Health Plan contracted with CMS as outlined in this Attachment. Medicare includes IEHP Health Plan's D-SNP product as well as the Capitated Financial Alignment Demonstration, also known as the "Duals Pilot Project," which is the pilot program seeking to integrate care across delivery systems for Dual Eligible Beneficiaries, as developed by CMS and the California Department of Health Care Services.

1.8. **Medicare Advantage Organization (MAO)** means a Health Plan or Provider Sponsored Organization that has entered into an agreement with the CMS to provide Medicare beneficiaries with health care options.

1.9. **Member** means an individual who has enrolled in or elected coverage through a MAO.

1.10. **Provider** means a First Tier Entity (Riverside County Regional Medical Center).

## II. ACCESS: RECORDS AND FACILITIES

Provider agrees:

2.1. To give the Department of Health and Human Services (HHS), CMS and the Comptroller General or their designees the right to audit, evaluate, and inspect any books, contracts, computer or other electronic systems, medical records, patient care documentation, and other records of Provider, its contractors, subcontractors, or related entities for the later of ten (10) years, or for periods exceeding ten (10) years, for reasons specified in the federal regulation. [422.504(e)(2), (3), and (4); 422.504(i)(2)(ii)]

2.2. To safeguard the privacy and confidentiality of any information that identifies a particular Member, and abide by all Federal and State laws regarding confidentiality and disclosure of medical records, or other health and enrollment information. [422.118(a)]

2.3. To maintain the records and information of Members in an accurate and timely manner. [422.118(c)]

2.4. To ensure that medical information pertaining to Members is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas. [422.118(b)]

2.5. To comply with MAO's standards for timeliness for appointments and waiting times for each type of service. [422.112(a)(6)(i)]

2.6. To ensure timely access by Members to the records and information that pertain to them. [422.118(d)]

## III. ACCESS: BENEFITS AND COVERAGE

Provider agrees:

3.1. To not discriminate based on health status. [422.110(a)]

3.2. Unless otherwise addressed within the Agreement or its attachments, MAO is required to pay for emergency and urgently needed services consistent with federal regulations, if such services are MAO's liability. [422.100(b)]

3.3. Unless otherwise addressed within the Agreement or its attachments, MAO is required to pay for renal dialysis services for Members temporarily outside the service area consistent with federal regulations, if such services are MAO's liability. [422.100(b)(1)(iv)]

3.4. To direct access to mammography screening and influenza vaccinations. [422.100(g)(1)]

3.5. To not collect any co-payment or other cost sharing for influenza vaccine and pneumococcal vaccines. [422.100(g)(2)]

3.6. To direct access to in-network women's health provider for women for routine and preventative services. [422.112(a)(3)]

3.7. To have approved procedures to identify access and establish a treatment plan for Members with complex or serious medical conditions. [422.112(a)]

3.8. To provide access to benefits in a manner described by CMS. [422.112(a)(8)]

3.9. To maintain procedures to ensure that Members are informed of specific health care needs that require follow-up and receive, as deemed medically necessary by Provider, training in self-care and other measures that Members may take to promote their own health. [422.112(b)(5)]

## IV. MEMBER PROTECTIONS

Provider agrees:

4.1. To work with the MAO regarding conducting a health assessment of all new Members within ninety (90) days of the effective date of enrollment. [422.112(b)(4)]

4.2. To provide all covered benefits in a manner consistent with professionally recognized standards of health care. [422.504(a)(3)(iii)]

4.3. To comply with all confidentiality and Member record accuracy requirements. [422.504(a)(13); 422.118)]

4.4. To document in a prominent place in the medical record whether or not an individual has executed an advance directive. [422.128(b)(1)(ii)(E)]

4.5. To hold harmless and protect Members from incurring financial liabilities that are the legal obligation of the MAO or capitated provider organization. In no event, including but not limited to, nonpayment or breach of an agreement by the MAO, First Tier Entity, or intermediary, shall Provider bill, charge, collect a deposit from or receive other compensation or remuneration from a Member. Provider shall not take any recourse against the Member, or a person acting on behalf of the Member, for services provided. This provision does not prohibit collection of applicable coinsurance, deductibles, or copayments, as specified in the Evidence of Coverage. This provision also does not prohibit collection of fees for non-covered services, provided the Member was informed in advance of the cost and elected to have non-covered services rendered. [422.504(g)(1)(i); 422.504(i)(3)(i)]

4.6. That Members eligible for Medicare and Medicaid will not be liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts, and Provider will accept the MAO payment as payment in full or bill the appropriate State source. [422.504(g)(1)(iii)]

4.7. If the CMS Agreement is terminated or is not renewed or the MAO becomes insolvent, to protect Members who are hospitalized from loss of health care benefits through the discharge date and through the period of time CMS premiums are paid. [422.504(g)(2) and (3)]

4.8. To provide for continuation of health care benefits for all Members for the duration of the contract period for which CMS premiums have been paid. [422.504(g)(2) and (3)]

4.9. To ensure that services are provided in a culturally competent manner to all Members, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds. [422.112(a)(8)]

4.10. To address the special needs of Members who are members of specific ethnic and cultural populations such as, but not limited to, the Vietnamese and Latino populations. Provider shall in its policies, administration, and services practice the values of: (a) honoring the Member's beliefs, traditions and customs; (b) recognizing individual differences within a culture; (c) creating an open, supportive and responsive environment where difference are valued, respected and managed; (d) through cultural diversity training, foster in staff and/or providers' attitudes and interpersonal communication styles which respect Member's cultural backgrounds; and (e) referring members to culturally and linguistically appropriate community services program. In addition, Provider shall provide translation of written materials in the languages served. Written materials to be translated include, but are not limited to, signage, the member service guide, enrollee information, notices, marketing information and welcome packages. [422.112(a)(8)]

4.11. To educate Members regarding their health needs; share findings of the Member's medical history and physical examinations; discuss potential treatment options, side effects and management of symptoms; recognize that the Member has the final say in the course of action to take among clinically acceptable choices.

4.12. To not encourage disenrollment of a Member because of the onslaught of ESRD. [422.110(b)]

## V. DELEGATION

Provider agrees:

5.1. To perform and maintain delegated functions consistent with MAO's contractual obligations under the CMS Agreement. [422.504(i)(3)(iii)]

5.2. That MAO may only delegate activities or functions to a Provider, related entity, contractor or subcontractor in a manner consistent with the requirements set forth in 42 CFR § 422.504(i)(4)(i). [422.504(i)(3)(ii)]

5.3. To comply with MAO's policies and procedures as set forth in the Medicare Advantage Participating Provider Operations Manual, including, without limitation, provisions that require a written arrangement to: (i) specify delegated activities and reporting responsibilities; (ii) provide for revocation of the delegated activities and reporting requirements or specify other remedies in instances where CMS or MAO determines that Provider and/or delegated parties have not performed satisfactorily; (iii) specify that the performance of Provider and/or delegated parties shall be monitored by MAO on an ongoing basis and formally reviewed by the MAO at least annually; (iv) specify that the credentials of medical professionals affiliated with Provider and/or delegated parties will be either reviewed by MAO or the credentialing process will be reviewed and approved by MAO and MAO shall audit the credentialing process on an ongoing basis; and (v) specify that Provider and/or delegated parties, in the performance of such delegated activities, shall comply with all applicable Medicare laws, regulations, and CMS instructions. [422.504(i)(4)]

5.4. That if MAO delegates selection of providers, contractors, or subcontractors to Provider or another organization, MAO retains the right to approve, suspend, or terminate any such arrangement. [422.504(i)(5)]

5.5. That any contract delegating activities or functions to a Provider, related entity, contractor or subcontractor, shall include language that incorporates the Capitated Financial Alignment Demonstration product offering, also known as the "Duals Pilot Project," i.e. the definition of Medicare as specified hereinabove.

## VI. PAYMENT AND FEDERAL FUNDS

Provider agrees:

6.1. To include, when applicable, specific payment and incentive arrangements in agreement with all Downstream Entities. [422.208]

6.2. To pay claims promptly according to CMS standards and comply with all payment provisions of state and federal law. CMS requires non-contracted provider clean claims to be paid within thirty (30) days of receipt, interest on clean claims to be paid in accordance with §§ 1816 and 1842(c)(2) of the Social Security Act if such claims are not paid within 30 days, and other claims from non-contracted provider to be paid or denied within 60 days of request. [422.520(a)]

6.3. MAO is obligated to pay a contracted Provider under the terms of the contract between the MAO and the Provider. [422.520(b)]

6.4. That Members health services are being paid for with Federal funds, and as such, payments for such services are subject to laws applicable to individuals or entities receiving Federal funds.

## VII. REPORTING AND DISCLOSURE

Provider agrees:

7.1. To submit to MAO all data, including medical records, necessary to characterize the content and purpose of each encounter with Member. [422.310(b)]

7.2. To submit and certify the accuracy, completeness and truthfulness of all encounter data. [422.504(a)(8); 422.504(l)]

7.3. To adhere to and comply with all reporting requirements as set forth in 42 C.F.R. 422.516 and the requirements in 42 C.F.R. 422.310. [422.504(a)(8)]

7.4. To submit, as required by CMS, a complete and accurate risk adjustment data, and a sample of the medical records for validation of risk adjustment data. [422.310(d)(3), (4); 422.310(e)]

## VIII. QUALITY ASSURANCE / QUALITY IMPROVEMENT

Provider agrees:

8.1. To cooperate with an independent quality review and improvement organization's activities pertaining to provision of services for Members. [422.152(a)]

8.2. To comply with MAO's medical policy, Quality Assurance program, and Medical Management program. [422.152; 422.202(b); 422.504(a)(5)]

## IX. COMPLIANCE

Provider agrees:

9.1. That the MAO or First Tier Entity must notify any Provider, in writing, of the reason(s) for denial, suspension or termination determinations that affect health care professionals, the right to appeal the action, and the process and timing for requesting a hearing. [422.202(d)(1)]

9.2. That MAO and First Tier Entity must provide at least 60 days written notice to each other before terminating the contract without cause. [422.202(d)(4)]

9.3. With respect to Downstream Entities, to provide both the First Tier Entity and the MAO at least 60 days written notice before terminating a contract without cause. [422.202(d)(4)]

9.4. To comply with HIPAA administrative simplification rules at 45 CFR Parts 160, 162 and 164, and Federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including but not limited to applicable provisions of Federal criminal law, the False Claims Act and the anti-kickback statute. [422.504(h)]

9.5. To meet the requirements of all other laws and regulation, including Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act, and all other laws applicable to recipients of Federal funds.

9.6. To comply with (and require that all Downstream Entities comply with) all applicable MAO procedures and MAO's Medicare Advantage Participating Provider Operations Manual including, but not limited to, the accountability provisions. [422.504(i)(3)(ii)]

9.7. To comply with (and require that all Downstream Entities comply with) applicable state and Federal laws and regulations, including Medicare laws and regulations and CMS instructions. [422.504(i)(4)(v)]

9.8. To not employ or contract with (and require that all Downstream Entities not employ or contract with) individuals excluded from participation in Medicare under Section 1128 or 1128A of the Social Security Act. [422.752(a)(8)]

9.9. To adhere to Medicare's appeals, expedited appeals and expedited review procedures for Members, including gathering and forwarding information on appeals to MAO, as necessary. [422.562(a)]

9.10. To adhere to Medicare's grievance and expedited grievance procedures for Members, including gathering and forwarding information to MAO, as necessary. [422.562(a); 422.564]

9.11. To adhere to all guidelines and requirements for marketing as set forth by CMS. This includes, but is not limited to, discouraging Providers from [42 CFR 422.2268; 423.2268]:

- 9.11.1 Attempting to explain MAO membership and costs;
- 9.11.2 Being the exclusive source of membership information;
- 9.11.3 Acting as agents of the MAO;
- 9.11.4 Acting outside their role as medical providers of care;
- 9.11.5 Discriminating in favor of "healthy" patients.

9.12. Providers may do the following:

- 9.12.1. Display plan-marketing materials for all plans with which the Provider participates, or display materials for those plans that provide them;
- 9.12.2. In compliance with Medicare marketing guidance and regulations, cooperatively advertise and market with MAO.

## X. ADOPTION OF MEDICARE CONTRACT REQUIREMENTS

Provider agrees:

10.1. That all contracts must be signed and dated.

10.2. To serve Members during the term of this Agreement.

10.3. To comply with the regulatory requirements and MAO's guidelines promulgated by Medicare, which are more fully documented in MAO's policies, procedures, and manuals. [422.202(b)]

10.4. To comply with Medicare laws, regulations and CMS instructions which are more fully documented in MAO's policies, procedures and manuals. [422.504(i)(4)(v)]

10.5. That any services or other activities performed by Provider in accordance with a contract between MAO and Provider are consistent and comply with MAO's obligations under the CMS Agreement. [422.504(i)(3)(iii)]

## XI. INTERPRETATION OF ATTACHMENT

Provider and MAO agree:

11.1. Except as provided in this Attachment, all other provisions of the Agreement between MAO and First Tier Entity not inconsistent herein shall remain in full force and effect.

11.2. This Attachment shall remain in force as a separate but integral addition to such Agreement to ensure compliance with required CMS provisions, and shall terminate upon the termination of such Agreement.

11.3. For purposes of Medicare Members, the provisions of this Attachment and Federal Law shall prevail.