Non-Minnesota Provider Requirements for Medicare

In addition to other requirements specified in the Administrative Requirements from Medica, the following requirements ("Requirements") apply to all Medicare products from Medica.

1. Definitions.

(a) **Affiliate**. Any person, partnership, corporation, or other form of enterprise including subsidiaries that directly or indirectly control, are controlled by, or are under common control with a party.

(b) **Benefit Contract**. A plan of health care coverage issued by Medica for each Medica Medicare product that contains the terms and conditions of a Member's coverage.

(c) **CMS Contract**. A contract between the Centers for Medicare and Medicaid Services ("CMS") and Medica Health Plans or an Affiliate of Medica Health Plans for the provision of Medicare benefits pursuant to the Medicare program.

(d) **Downstream Entity**. Any party that enters into an acceptable written agreement below the level of the arrangement between Medica and Provider. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.

(e) **Medicare**. The federal insurance program for aged and disabled people as defined under Public Law 89-97 (42 U.S.C. § 1395 et. seq.).

(f) **Medicare Advantage**. The Medicare managed care program established for beneficiaries.

(g) **Primary Care Clinic.** A Clinic selected by Medica that will perform certain services related to the coordination, referral and delivery of Health Services for each Medica Medicare Advantage Member who has designated such Participating Provider as his or her primary care clinic.

(h) **Primary Care Physician.** A Clinic Physician accepted by Medica to coordinate Health Services for Medica Medicare Advantage Members and practicing in the area of family practice, general internal medicine, obstetrics and gynecology or pediatrics.

2. **Provision of Health Services and Quality of Care**. Provider will provide Health Services in a manner consistent with professionally recognized standards of care and in accordance with the standard of practice in the community in which such Provider renders Health Services as required pursuant to the CMS Contract and all applicable state and federal laws. In addition, Provider will provide Health Services in a manner so as to assure quality of care and treatment,

including without limitation compliance with all applicable Medicare laws, regulations and sub-regulatory guidance.

3. **Access to Health Services**. Provider will provide Health Services in a culturally competent manner to all Members, including Members with limited English proficiency or reading skills and diverse cultural and ethnic backgrounds. Provider will not discriminate against any person based on his or her race, ethnicity, color, creed, religion, national origin, sex (including, but not limited to, gender identity and sex stereotyping), gender, health status including mental and physical medical conditions, marital status, familial status, status with regard to public assistance, disability, sexual orientation, age, receipt of health care services, claims experience, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), geographic location, political beliefs, membership or activity in a local commission, or any other classification protected by law.

4. **Data Collection**. Provider will submit to Medica, within the timeframe specified by Medica, all data, including medical records, necessary to characterize the context and purpose of each encounter with a Member in the manner and to the extent required by CMS. Provider will certify, in writing, the completeness and accuracy of all such data.

5. Member Complaints. Provider will cooperate with Medicare grievance, appeals and expedited appeals procedures.

6. Physician Incentive Plan. Provider will comply with all applicable provisions of 42 CFR §§ 417.479 and 422.208, which requires that payments made under a physician incentive plan must not reduce or limit medically necessary services to a Medicare Member. This applies to physicians, physician groups, and subcontractors. Payments based on care furnished, patient satisfaction, and participation on committees are not considered payments for purposes of this section.

7. **Excluded and Precluded Individuals and Entities.** Provider will comply with the following requirements regarding excluded individuals and entities.

(a) **Definitions.** For purposes of this Section 7, the following definitions shall apply:

I. **Person with an Ownership or Control Interest:** A person or corporation that: (i) has an ownership interest, directly or indirectly, totaling 5% or more in Provider; (ii) has a combination of direct and indirect ownership interests equal to 5% or more in Provider; (iii) owns an interest of 5% or more in any mortgage, deed of trust, note or other obligation secured by Provider, if that interest equals at least 5% of the value of the property or assets of the Provider; or (iv) is an officer or director of Provider (if organized as a corporation) or is a partner in the Provider (if organized as a partnership).

II. **Subcontractor:** An individual, agency or organization to which Provider has contracted (or a person with an employment, consulting or other arrangement with Provider) for the provision of items and services that are significant and material

to Provider's contract with Medica and Medica's obligations under the CMS Contract.

(b) **Excluded Individuals and Entities.**

I. Provider warrants that Provider has not been: (i) convicted of a criminal offense related to Provider's involvement in any federally funded government program; (ii) debarred, suspended or otherwise excluded from participation in any federally funded government program, as required by applicable federal law; or (iii) sanctioned by the U.S. Department of Health and Human Services ("HHS") Office of Inspector General ("OIG"). In addition, Provider does not appear on: (i) the OIG List of Excluded Individuals/Entities ("LEIE"); or (ii) the General Service Administration's System for Award Management ("SAM"). Provider agrees to search monthly, and upon contract execution or renewal, and credentialing, the LEIE and SAM to verify that Provider's employees, officers, directors, agents, Subcontractors and any Person with an Ownership or Control Interest: (i) are not debarred, suspended or otherwise excluded from participation in any federally funded government program; (ii) have not been convicted of a criminal offense related to that person's or entity's involvement in any federally funded government program; and (iii) have not been sanctioned by the OIG.

II. Provider further warrants that Provider will not, during the term of the Agreement, employ, purchase products or services from, or contract with any Subcontractor who: (i) has been convicted of a criminal offense related to the individual's or entity's involvement in any federally funded government program; (ii) is listed as debarred, suspended or otherwise excluded from participation in any federally funded government program as required by applicable federal law; or (iii) has been sanctioned by the OIG.

III. Provider shall provide written notice to Medica within five (5) calendar days of the date Provider knows, or has reason to know, that Provider or any Subcontractor has been: (i) convicted of a criminal offense related to the individual's or entity's involvement in any federally funded government program; (ii) listed as debarred, suspended or otherwise excluded from participation in any federally funded government program as required by applicable federal law; or (iii) sanctioned by the OIG.

(c) **Preclusion List**

I. Provider warrants that Provider is not currently revoked from Medicare, is not under an active reenrollment bar, and CMS has not determined that the Provider's underlying conduct that led to the revocation is detrimental to the best interests of the Medicare Program.

II. Provider further warrants that Provider has not engaged in behavior for which CMS could have revoked Provider to the extent applicable if they had been

enrolled in Medicare, and CMS determines that the underlying conduct that would have led to the revocation is detrimental to the best interests of the Medicare program.

a. If Provider is on Preclusion List:
    1. Member will not have any financial liability for services, items, or drugs furnished, ordered, or prescribed to Member by a Medica contracted Provider who is on the Preclusion List.
    2. Following the expiration of the 60 day reconsideration period for the Precluded Provider, if the Provider remains on the Preclusion list:
        a. Provider will no longer be eligible for payment from Medica and will be prohibited from pursuing payment from the Member as stipulated by the terms of the CMS Contract; and
        b. Provider will hold financial liability for services, items, and drugs that are furnished, ordered, or prescribed after the expiration of the 60 day reconsideration period, at which point the Provider and the Member will have already received notification of the preclusion.

8. Compliance Training.

(a) Provider certifies that it will annually provide compliance training that meets the guidelines set by CMS from time to time ("Compliance Training"), to all of its personnel and/or employees (as required by CMS) responsible for the administration or delivery of services to Members. To the extent required by CMS, such Compliance Training will include such other applicable compliance and/or fraud, waste and abuse training directed by CMS. Provider further certifies that for Downstream Entities responsible for the administration or delivery of services to Members, Provider will: (i) communicate general compliance training information to its Downstream Entities; and (ii) within ninety (90) calendar days of contracting and annually thereafter, provide fraud, waste and abuse training directly to its Downstream Entities or provide appropriate fraud, waste and abuse training materials to its Downstream Entities. Provider will provide, at Medica's request, an attestation that Provider has fulfilled the required Compliance Training hereunder for its personnel, employees, and Downstream Entities (to the extent required or instructed by CMS) in compliance with this section.

(b) Upon reasonable written notice from Medica to Provider, Provider shall permit Medica personnel to review Provider's policies and procedures including, without limitation, Compliance Training program materials and methods of distribution to Downstream Entities related to Provider's Compliance Training provided under this section.

9. No Opting Out of Medicare; Participation in Medicare. Provider may not employ or contract with any providers who have opted out of Medicare by filing with a Medicare carrier an affidavit promising to furnish Medicare covered services to Medicare beneficiaries only through

private contracts with such beneficiaries. Provider is certified for participation in Medicare, to the extent Provider is a provider type eligible to be certified for participation in Medicare.

10. **Compliance Requirements**. In addition to informing all related entities, contractors and/or subcontractors that payments they receive are, in whole or in part, from federal funds, Provider will, and will cause Downstream Entities to, comply with:

(a) all applicable state and federal laws, regulations and sub-regulatory guidance;

(b) all applicable Medicare laws, regulations, and CMS sub-regulatory guidance;

(c) all state and federal laws and regulations designed to prevent or ameliorate fraud, waste or abuse, including but not limited to, applicable provisions of Federal criminal law, the False Claims Act (31 U.S.C. § 3729 et. seq.) and the anti-kickback statute (Section 1128B(b) of the Social Security Act); and

(d) all applicable state and federal laws and regulations designed to protect Medica member privacy including, but not limited to: (i) the Health Insurance Portability and Accountability Act of 1996 and administrative simplification rules promulgated thereunder at 45 CFR parts 160, 162, and 164, as amended ("HIPAA"); and (ii) the Health Care Administrative Simplification Act of 1994, Minnesota Statutes, Section 62J.50 et. seq., as amended.

11. **Records**. Provider will prepare and maintain accurate and timely medical records and information for all Members who receive services from Provider. Provider will ensure that Members have timely access to medical records and information that pertain to them. Provider agrees to document in a prominent place in the Member's medical record whether or not the Member has executed an Advance Directive. Provider will safeguard the privacy of any health information that identifies a Member and will abide by all federal and state laws, regulations and sub-regulatory guidance regarding privacy, confidentiality and disclosure of medical records and other health and member information. Provider shall maintain records arising out of or related to the Agreement and the CMS Contract for at least ten (10) years from the date of termination or expiration of the Agreement or final audit, whichever is later, or such longer period required by law or regulation.

12. Government Access to Records. CMS, the Secretary of Health and Human Services ("HHS") Inspector General, and the Comptroller General, or their designees, will have the right to audit, evaluate and inspect any premises, physical facilities, equipment, books, contracts, computer or electrical systems, medical records, patient care documentation and other records belonging to Provider that pertain to the Provider's agreement with Medica and other program related matters deemed necessary by the person conducting the audit, evaluation, or inspection, consistent with 42 CFR § 438.3(h). If CMS, HHS Inspector General, or the Comptroller General, or their designees, determine that there is a reasonable probability of fraud or similar risk, CMS, HHS Inspector General, or the Comptroller General, or their designees, may audit the Provider at any time. This right will extend through ten (10) years from the date of termination or expiration of the Agreement or final audit, whichever is later, or longer in certain circumstances as required by law or regulation.

13. Medica Access to Records. Provider shall grant Medica or its designees such audit, evaluation, and inspection rights identified in Section 12 herein, as are necessary for Medica to comply with its obligations under the CMS Contract. Whenever possible, Medica will give Provider reasonable notice of the need for such audit, evaluation or inspection, and will conduct such audit, evaluation or inspection at a reasonable time and place.

14. Overpayments. Upon Provider's identification of an overpayment from Medica, Provider must report to Medica receipt of the overpayment, return the overpayment to Medica within sixty (60) calendar days after the date Provider identifies the overpayment, and notify Medica of the reason for the overpayment, pursuant to Section 1128J (d) of the Social Security Act.

15. **Exception to Protocols**. Any protocol that requires a Medicare Advantage Member to obtain a referral from his/her Care System/Primary Care Physician, shall not apply to the following Health Services:

(a) mammography screening;
(b) influenza vaccine; and
(c) preventive and routine services provided by women's health specialists.

16. **Member Protection Provisions**. Provider will not hold financially responsible, collect or attempt to collect additional reimbursement for Health Services from any Member, except for (i) Copayments or Coinsurance, (ii) Deductibles, (iii) any service rendered by Provider that is ineligible for coverage under the Member's Benefit Contract; provided, however, that the Member has been informed, in writing, prior to performance of the service, that the non-covered service or treatment to be rendered will be the Member's liability and therefore, not covered under the Benefit Contract. Provider must obtain written authorization from the Member, prior to performance of the service, indicating that the Member is fully aware that the services being provided may not or will not be covered by Medica under the Member's Benefit Contract, and indicating that the Member agrees to be financially responsible for such non-covered service or treatment if rendered.

Members receiving services at hospitals or ambulatory surgical centers may not be held liable for any service provided for an authorized procedure (e.g. anesthesiologist/radiologist).

In no event including, but not limited to, Medica's non-payment, insolvency or breach of the Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Member or any other person(s) acting on a Member's behalf or hold any Member financially liable for any payments or other fees that are the legal obligation of Medica under the Agreement or under Medica's contract with CMS.

Provider will not hold Members that are eligible for both Medicare and Medicaid financially responsible for Medicare Part A and Part B Copayments, Coinsurance, or Deductibles when Medicaid is responsible for payment of such amounts. Medica will not impose cost-sharing in excess of the cost-sharing permitted under Title XIX of the Social Security Act. Providers will accept Medica's payment for Health Services as payment in full, or will bill the appropriate State source.

17. **Prompt Payment for Health Services**. Medica will pay Provider for Health Services in accordance with applicable state and federal law as related to the prompt payment of claims.

18. **General Request for Services**. As applicable, Provider or Member may make a request for Health Services to the Member's Medicare Advantage Care System ("System") or Medica, as appropriate. System will evaluate such request, within a timeframe, at the discretion of Medica, that will allow completion of the initial review within ten (10) working days, or shorter time period as required by law. System will promptly communicate its decision to approve a request to Provider by telephone and in accordance with law, the CMS Contract, and the Administrative Requirements from Medica (collectively referred to as "Utilization Review Requirements"). System will promptly submit requests that it does not approve to Medica for review by Medica. Medica will notify Provider of an approval of its review of a request by telephone and in accordance with the Utilization Review Requirements. If the decision from Medica is to deny the request, Medica will notify Provider and Member, or his or her authorized representative, in accordance with the Utilization Review Requirements. Each party must notify the other party of any information it has regarding applicable law. The Member, or Provider on behalf of the Member, may appeal the decision from Medica in accordance with the Complaints and Appeals process described in the Benefit Contract and in the CMS Contract.

19. **Access to Health Services**. Provider will, in accordance with the standards set forth below, provide Health Services:

(a) Emergency Services. Emergency Services and Post-Stabilization Care Services will be available to Members twenty-four (24) hours per day and seven (7) days per week, including a twenty-four (24) hours per day number for Members to call in case of Medical Emergency or an Emergency Medical Condition.

(b) Urgent Services. Urgent Services will be made available to Members twenty-four (24) hours per day and seven (7) days per week. Appointment times for Urgent Services will be made available to Members within twenty-four (24) hours of the time services are requested.

(c) Routine and Preventive Services. Appointment times for routine and preventive services will not exceed forty-five (45) days from the date of a Member's request for routine and preventive services.

(d) Specialty Care. Appointments for a specialist will be made in accordance with the time frame appropriate for the needs of the Member, or the generally accepted community standards.

(e) Lab and X-Ray Services. Appointment times for lab and x-ray services will not exceed sixty (60) days for regular appointments and forty-eight (48) hours for Urgent Services.

20. **Accessibility for Disabled Members**. Provider will comply with applicable provisions of the Americans with Disabilities Act of 1990, 42 U.S.C. § 12101. et. seq., and regulations

promulgated pursuant to it. Provider will also comply with 28 CFR § 35.130(d), which requires that services, programs, and activities be provided in the most integrated setting appropriate to the needs of Members with disabilities. Provider also will take reasonable steps to ensure meaningful access by Limited English Proficient Persons (LEPs). The following four factors shall be considered: (1) the number or proportion of LEP persons eligible to be served; (2) the frequency with which LEP individuals come in contact with the Provider; (3) the nature and importance of the program, activity, or service provided by the program to people's lives; and (4) the resources available to the Provider, and costs.

21. **Member Rights**. Provider will comply with any applicable state and federal laws that pertain to Member rights and, when providing services to a Member, ensure the Member's right to:

(a) Receive information pursuant to 42 CFR § 438.10;

(b) Be treated with respect and with due consideration for the Member's dignity and privacy;

(c) Receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand;

(d) Participate in decisions regarding his or her health care, including the right to refuse treatment;

(e) Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other federal regulations on the use of restraints and seclusion;

(f) Request and receive a copy of his or her medical records pursuant to state law and 45 CFR Parts 160 and 164, subparts A and E, and request to amend or correct the record as specified in 45 CFR §§ 164.524 and 164.526;

(g) Be furnished health care services in accordance with 42 CFR § 438.206 through § 438.210; and

(h) Be free to exercise his or her rights and that the exercise of these rights will not adversely affect the way the Member is treated.

For more information on Member Rights as they apply to the Medicare products by Medica click on the links below:

Member Rights and Responsibilities

22. **Medical Error Reporting**. Medica encourages hospital Providers to report through Leapfrog, a national patient safety initiative, and develop and implement patient safety policies to systematically reduce medical errors. Such policies may include systems for reporting errors, and systems analysis to discover and implement error-reducing technologies.

23. Medicare Outpatient Observation Notice. Hospitals, including critical access hospitals (CAH), will provide written and oral notification to all Members receiving observation services as outpatients for more than 24 hours that they are an outpatient receiving observation services, and are not an inpatient of the hospital or CAH. Such notice must be delivered no later than 36 hours after observation services are initiated or sooner if the Member is transferred, discharged, or admitted. For more information on the required notice, see the link below.

Centers for Medicare & Medicaid Services

24. **Lobbying Disclosure.** Provider will and will require that its subcontracted providers, if any, certify that, to the best of their knowledge, understanding, and belief:

No federal appropriated funds have been paid or will be paid for salary, expenses or otherwise by or on behalf of Provider or, as applicable, any subcontracted provider to any person influencing or attempting to influence an officer or employee of an agency, a member of Congress or state legislature, an officer or employee of Congress or state legislature, or an employee of a member of Congress or state legislature in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, the modification of any federal contract, grant, loan, or cooperative agreement, or in any activity designed to influence legislation or appropriations pending before Congress or state legislature.

If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any federal agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with federal government health care program products, Provider will and, as applicable will require that its subcontracted providers, complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

25. **Delegated Activities.** Provider acknowledges and agrees that Medica oversees and is accountable to CMS for any functions and responsibilities described in the CMS Contract and applicable to Medicare regulations, including those that Medica may delegate to Provider. If Medica delegates any of its functions and responsibilities under the CMS Contract to Provider pursuant to a delegation agreement with Provider, the following will apply in addition to the other provisions stated in these Requirements:

(a) Provider will perform those delegated activities specified in the delegation agreement, if any, and will comply with any reporting responsibilities as set forth in such delegation agreement.

(b) If Medica has delegated to Provider the selection of health care providers to be participating providers in the provider network of Medica for Medicare products, Medica retains the right to approve, suspend or terminate the participation status of such health care providers.

(c) If Medica has delegated to Provider any activities related to the credentialing of health care providers, Provider must comply with all applicable CMS requirements for

credentialing, including but not limited to the requirement that the credentials of medical professionals must either be reviewed by Medica, or the credentialing process must be reviewed, pre-approved and audited on an ongoing basis by Medica.

(d) Provider acknowledges that Medica or its designee will monitor Provider's performance of any delegated activities on an ongoing basis. If Medica or CMS determines that Provider has not performed satisfactorily, Medica may sanction Provider or revoke any or all delegated activities and reporting requirements. Provider acknowledges and agrees that to the extent CMS directs revocation, Medica shall provide immediate written notice of such to Provider, and such revocation shall become effective as directed by CMS. Provider will cooperate with Medica regarding the transition of any delegated activities or reporting requirements that have been revoked by Medica. No additional financial obligations shall accrue to Medica with respect to such revoked activities from and after the date of such revocation in accordance with this section.

26. **Compliance with Medica's Contractual Obligations with CMS.** To the extent that Provider participates in Medicare products of Medica, it will participate pursuant to the CMS Contract under the terms and conditions agreed to by Medica and CMS. Provider understands that this Agreement involves receipt by the Provider of payments that are, in whole or in part, from federal funds. The Provider, and all related entities, contractors and/or subcontractors are therefore subject to laws applicable to individuals and entities receiving federal funds. Any services rendered to Members under the Agreement shall be consistent and comply with Medica's contractual obligations with CMS. Provider acknowledges and agrees that Medica oversees and maintains ultimate responsibility for adhering to and otherwise fully complying with the terms and conditions of the CMS Contract and for ensuring that Provider satisfies its obligations in compliance with such contracts. In accordance with the CMS Contract, payments to Provider may be suspended by Medica for a determination of a credible allegation of fraud against Provider.

27. Offshore Services. Provider represents that no subcontractor hereunder performs any Medicare-related work in any country that is not one of the fifty United States or one of the United States Territories (an "Offshore Subcontract"). In the event that Provider desires to enter into an Offshore Subcontract, Provider must get Medica's prior written consent, which may be conditioned upon the consent of Medica's regulators and Medica's review of applicable law. If Medica gives consent to Provider to provide Offshore Services, Medica still reserves the right to later revoke that consent at Medica's sole discretion, or if Medica is compelled to do so due to any regulatory instruction or legal requirement. Provider shall comply with all CMS requirements and instructions applicable to offshore subcontracting including, but not limited to, completing an "Offshore Subcontractor Information and Attestation Form."

28. Termination Due to Government Action.

(a) In the event Medica ceases to offer a Medicare product and/or terminates (and does not replace) the applicable CMS Contract, the Agreement or portion thereof may be terminated by Medica effective as of the effective date of the termination of the applicable Medicare product or CMS Contract.

(b) Medica shall be entitled to remove the applicable population served by the Agreement who are Medica Medicare members if the applicable contract between CMS and Medica is terminated or non-renewed unless CMS and Medica agree to the contrary.

To the extent applicable, termination of the Agreement shall be carried out in accordance with the termination requirements stated in 42 CFR § 422.506 and § 422.512.

29. Medicare Product Payments Subject to Sequestration. All payments to providers under Medica's Medicare plans, including any Medicare plans offered by Medica in the future, are subject to the federal sequestration of payments provisions. Payments to providers under their contracts with Medica are reduced accordingly. Medica's provider contracts require compliance with Medica's Administrative Requirements, including this provision in the Provider Requirements for Medicare so please be advised that this acknowledgement of sequestration is a part of your provider contract.