MEDICARE ADVANTAGE ADDENDUM

CMS requires that specific terms and conditions be incorporated into the agreement between a Medicare Advantage Organization or First Tier Entity and a First Tier Entity or Downstream Entity to comply with the Medicare laws, regulations, and CMS instructions

This Addendum shall supersede and replace any inconsistent provisions to the Agreement between Network and Provider pursuant to which, Provider renders Health Care Services to Members, but only to the extent of such inconsistency in order to ensure compliance with required CMS provisions, and shall continue concurrently with the term of such Agreement.

NOW, THEREFORE, the parties agree as follows:

Definitions:

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

Downstream Entity: any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit, below the level of the arrangement between an MA organization (or applicant) and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health, health-related 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 MA organization or applicant to provide administrative services or health care services for a Medicare eligible individual under the MA 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 MA 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 or related 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 or related 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 MA organization by common ownership or control and (1) performs some of the MA 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 MA organization at a cost of more than $2,500 during a contract period.

Required Provisions:

The Provider agrees to the following:

1. HHS, the Comptroller General, or their designees have the right to audit, evaluate, collect, 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 Provider, (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 (iv)]

2. HHS, the Comptroller General, or their designees have the right to audit, evaluate, collect, and inspect any records under paragraph 1 of this amendment directly from any first tier, downstream, or related entity. For records subject to review under paragraph 1, except in exceptional circumstances, CMS will provide notification to the MA organization that a direct request for information has been initiated. [42 C.F.R. §§ 422.504(i)(2)(ii) and (iii)]

3. **Provider** 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]

4. 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)]

5. 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. Provider 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)(iii)]

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

7. 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 Network is obligated to pay contracted providers under the terms of the contract between the Network and the Provider. [42 C.F.R. §§ 422.520(b)(1) and (2)]

8. **The Provider** 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)]

9. 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. 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.

   ii. The MA organization will monitor the performance of the parties on an ongoing basis in accordance with the agreement between Plan and Network.

   iii. 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. Credentialing will be performed and monitored in accordance with agreement between Plan and Network.

   iv. 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 the Agreement, the terms above control.

MEDICAID ADDENDUM

THIS MEDICAID ADDENDUM (the "Addendum") supplements the terms and conditions of that certain provider agreement (the "Agreement") by and between Network and the Provider. Pursuant to the Agreement, Provider renders Health Care Services to Members. HMO has entered into an agreement with AHCA (the "Medicaid Contract") to arrange for the provision of health care services to Members eligible for the Medicaid Program and enrolled in a Medicaid Benefit Plan offered by HMO (the "Medicaid Benefit Plan"). The following requirements specifically apply to

any Members that are enrolled under a Medicaid Benefit Plan ("Medicaid Members"). This Addendum is entered into for the purpose of ensuring compliance with Florida and Federal Medicaid laws, rules and regulations with respect to the Medicaid Benefit Plan and applies to Provider in its provision of services to HMO. This Addendum and the Agreement shall comply with 42 C.F.R. 438.230, 42 C.F.R 455.104, 42 C.F.R. 455.105 and 42 C.F.R. 455.106. All capitalized terms not set forth herein shall have the meanings set forth in the Agreement.

The provisions of this Addendum supplement the terms of the Agreement and are to be interpreted in a manner consistent with the terms of the Agreement, provided that to the extent the terms and conditions set forth in this Addendum conflict and cannot be reconciled with similar provisions elsewhere in the Agreement with respect to the provision of health care services to Medicaid Members, the terms and conditions in this Addendum shall prevail. In addition, to the extent that the terms or conditions of this Addendum conflict with a Medicaid Contract, the Medicaid Contract shall control as to Medicaid Members who are enrolled in a Medicaid Benefit Plan. Since the provisions of this Addendum apply to Provider, its Professional Staff, employees, contractors, subcontractors and individuals or entities performing services for or on behalf of Provider or any of the above named individuals or entities performing services related to the Agreement, all references to Provider herein shall also be references to Professional Staff, employees, contractors, subcontractors and individuals or entities performing services for or on behalf of Provider.

1. Provider shall and shall cause each member of its Professional Staff to comply with and abide by all applicable terms and conditions of the Medicaid Contract as well as all related state and federal laws, rules, regulations and guidelines related to the Medicaid lines of business.

2. Provider and each member of its Professional Staff is enrolled in or is eligible for participation in the Medicaid program under Title XIX of the Social Security Act. Provider acknowledges and agrees that if Provider or any member of its Professional Staff was involuntary terminated from the Medicaid Program other than for purposes of inactivity, Provider or such Professional Staff member is not considered eligible.

3. Provider shall secure and maintain workers' compensation insurance coverage for all of its employees connected with services provided to Medicaid Members pursuant to the Medicaid Contract and in compliance with the Florida Workers' Compensation Laws.

4. Provider and each member of its Professional Staff shall maintain complete and accurate fiscal, medical, social and other administrative records for medical services rendered to Medicaid Members and as are necessary to document the quality, appropriateness and timeliness of services performed under the Agreement and in compliance with applicable state and federal laws, rules and regulations and the Medicaid Contract. Provider shall and shall cause each member of its Professional Staff to maintain and retain said records for a period of at least ten (10) years after HMO's Medicaid Contract with AHCA is terminated and retained further if the records are under review or audit until the review or audit is complete. Said records will be made available for audit, review and/or other periodic monitoring upon request by HMO, AHCA, CMS or DHHS, or their respective designees.

5. Provider shall and shall cause each member of its Professional Staff to allow HMO, AHCA, and/or DHHS to evaluate and/or inspect, during normal business hours, or at any such other time as is required by HMO, AHCA and/or DHHS, in their discretion, necessary to ensure compliance with this Addendum, the Agreement and/or the Medicaid Contract between AHCA and HMO, and/or to ensure the health, safety and well-being of Medicaid Members.

6. Provider agrees and shall cause each member of its Professional Staff to agree to submit information for reports and clinical information, including without limitation Child Health Check-up where applicable, to HMO and/or AHCA, upon request.

7. Provider agrees and shall cause each member of its Professional Staff to agree to safeguard the confidentiality of information about Medicaid Members according to 42 C.F.R. Part 438.224.

8. Provider shall and shall cause each member of its Professional Staff to allow for timely access to care for all Medicaid Member appointments in accordance HMO's guidelines and regulations.

9. Payments due as a result of Covered Medical Services rendered to Medicaid Members shall be made by HMO to Provider within the time mandated, if any, by CMS, after all properly documented invoices and/or claims, and any documentation necessary for HMO to process such claims, have been received by HMO.

10. Nothing in this Addendum is intended to or shall (i) interfere with or hinder communications between Provider or its Professional Staff and Medicaid Members regarding patient treatment; (ii) prohibit Provider or its Professional Staff from discussing treatment options or non-treatment options with Medicaid Members that may not reflect HMO's position or that may not be covered by the Medicaid Benefit Plan; (iii) prohibit Provider or its Professional Staff from acting within the lawful scope of practice, from advising or advocating on behalf of Medicaid Member for the Medicaid Member's health status, medical care, or treatment or non-treatment options, including any alternative treatments that might be self-administered; (iv) prohibit Provider or its Professional Staff from advocating on behalf of a Medicaid Member in any grievance process, UM process, or individual authorization process to obtain necessary health care services; (v) require Provider to contract for more than one HMO product or otherwise be excluded; (vi) prohibit or restrict Provider or its Professional Staff from entering into a commercial contract with any other managed care plan; or (vii) prohibit Provider or its Professional Staff from providing inpatient services in a contracted hospital to Medicaid Member if such services are determined to be Medically Necessary and are Covered Medical Services.

11. Notwithstanding anything to the contrary herein, either party may terminate the Agreement, in accordance with the terms and conditions of the Agreement, with additional notice of such termination to AHCA and CMS.

12. Any contracts, agreements, or subcontracts entered into by Provider for the purposes of carrying out any aspect of the Agreement or this Addendum must include assurances that the individuals who are signing the contract, agreement or subcontract are so authorized

and that it includes all the requirements of the Agreement, this Addendum, and the Medicaid Contract as applicable. Provider acknowledges and agrees that if the performance of Provider or any Professional Staff member or the performance of their respective subcontractors, as it relates to the Agreement, this Addendum, or the Medicaid Contract, is inadequate, HMO shall have the right to revoke the delegation of duties and obligations under this Agreement and to, or impose other sanctions on, Provider and its Professional Staff. Furthermore, Provider will be obligated to revoke the delegation of duties and obligations to, or impose other sanctions on, its subcontractors at the request of HMO.

13. Provider shall and shall cause each member of its Professional Staff to cooperate with and participate in HMO's peer review, grievance, quality assurance and management program and utilization review and activities, and provide for monitoring and oversight, including monitoring of services rendered to Medicaid Members. Provider and each member of its Professional Staff rendering Covered Medical Services shall be licensed and credentialed in accordance with HMO's, or its designee's, credentialing and re-credentialing policies and procedures, this Addendum and HMO's Medicaid Contract.

14. Provider agrees and shall cause each member of its Professional Staff to agree that a Medicaid Member may be transferred immediately to another PCP or health plan if the Medicaid Member's health or safety is in jeopardy.

15. To the extent applicable, Provider agrees and shall cause each member of its Professional Staff to agree to perform Medicaid Member case management responsibilities and duties associated with its designation as a Primary Care Physician.

16. HMO shall not discriminate with respect to participation, reimbursement, or indemnification of Provider or its Professional Staff who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of such license or certification. This provision should not be construed as an "any willing" provider law, and it does not prohibit HMO from limiting Professional Staff participation to the extent necessary to meet the needs of Medicaid Members. Furthermore, this provision does not interfere with measures established by HMO that are designed to maintain quality and control costs.

17. HMO shall not discriminate against Provider or any member of its Professional Staff serving high-risk populations or those that specialize in conditions requiring costly treatments.

18. Provider shall and shall cause each member of its Professional Staff to maintain adequate record systems for recording services, charges, dates and all other commonly accepted information elements for services rendered to HMO and Medicaid Members.

19. Provider shall and shall cause each member of its Professional Staff to provide DHHS, the Florida Department of Elder Affairs, AHCA, including AHCA's Bureau of Medicaid Program Integrity (MPI) and the Medicaid Control Fraud Unit (MFCU), the right to inspect, evaluate, and audit all of the following related to HMO's provision of services under its Medicaid Contract:

- Pertinent books,
- Financial records
- Medical Records, and
- Documents, papers, and records of Provider or its Professional Staff involving financial transactions related to this Addendum.

20. Provider shall and shall cause each member of its Professional Staff to comply with HMO's cultural competency plan, as described in HMO's Provider Handbook.

21. Provider shall and shall cause each member of its Professional Staff to provide all Covered Medical Services to populations to be served in accordance with the terms and conditions of the Medicaid Contract and HMO's Provider Handbook.

22. Provider agrees and shall cause each member of its Professional Staff to agree that any community outreach and marketing materials relating to HMO's Medicaid Contract and Provider's participation in the Medicaid Benefit Plan, must be submitted by HMO to AHCA for written approval before use. Provider shall and shall cause each member of its Professional Staff to comply with all community outreach and marketing requirements set forth in the Medicaid Contract.

23. Provider shall and shall cause each member of its Professional Staff to abstain from making referrals for designated health services to health care entities with which Provider, a Professional Staff member or a member of Provider's or a Professional Staff member's family has a financial relationship.

24. Provider shall and shall cause each member of its Professional Staff to fully cooperate in all respects with other providers and health plans of transitioning Medicaid Members to assure maximum health outcomes for Medicaid Members.

25. Provider shall and shall cause each member of its Professional Staff to agree that in the event of any conflict between the terms and conditions of the Agreement and/or this Addendum and the Medicaid Contract as related to HMO's Medicaid Benefit Plan, the terms and conditions of the Medicaid Contract shall control.

26. In the event that the Agreement or this Addendum terminates or expires prior to the end of a period for which AHCA has made a payment to HMO, Provider shall and shall cause each member of its Professional Staff to continue to provide Covered Medical Services to Medicaid Members in accordance with the terms and conditions of the Agreement and this Addendum through the term of the period for which AHCA has paid HMO, the termination or expiration of the Agreement or this Addendum notwithstanding and until such time as the Medicaid Member has been transferred to another Participating Provider, unless the termination occurred for the benefit or protection of the Medicaid Member.

27. Provider shall look solely to HMO for compensation for services rendered hereunder, with the exception of nominal copayments or deductibles, pursuant to the Medicaid Contract. Neither Provider nor any member of its Professional Staff shall seek reimbursement or payment from Medicaid Members for Covered Medical Services rendered to such

Medicaid Members pursuant to or in connection with this Agreement. Upon the termination or expiration of the Medicaid Contract, payment for all services performed for eligible Medicaid Members prior to the effective date of termination will be the responsibility of HMO. Provider shall not hold either Medicaid Members or AHCA liable for the debts of Provider at any time, including termination of the Agreement or this Addendum for any reason, including the insolvency of HMO.

28. Payment of any claims by HMO shall be accompanied by an itemized accounting of the individual claims included in the payment, including but not limited to, the Medicaid Member's name, date of service, the procedure code, the service units, the amount of reimbursement and the identification of the Medicaid Benefit Plan under which payment is being made.

29. Provider agrees and shall cause each member of its Professional Staff to agree that it is required to cooperate fully in any audit, investigation or review by HMO, AHCA, MPI, MFCU, Florida Department of Elder Affairs or other state or federal entity and in any subsequent legal action that may result from such an audit, investigation or review involving the Agreement.

30. Provider agrees that it and its independent contractors and employees are subject to background checks conducted by HMO. HMO shall consider the nature of the work being performed in determining the level and scope of the background check. Provider agrees that it and its independent contractors and employees will cooperate with HMO in connection with its performance of any and all background checks under and pursuant to this Agreement.

31. Provider agrees that in addition to any other right to terminate the Agreement, AHCA or HMO may request immediate termination of the Agreement if, as determined by AHCA, Provider fails to abide by the terms and conditions of the Agreement, or in the sole discretion of AHCA, Provider fails to come into compliance with the Agreement within fifteen (15) days after receipt of notice from HMO specifying such failure and requesting Provider to abide by the terms and conditions thereof.

32. Provider agrees that in the event Provider is suspended or terminated for any reason, Provider may only utilize the applicable appeals procedures outlined in the Provider Handbook. No additional or separate right of appeal to AHCA or HMO is created as a result of HMO's act of suspending or terminating Provider.

33. The federal False Claims Act is a federal law that applies to fraud involving any contract or program that is federally funded, including Medicare and Medicaid. Health care entities that violate the federal False Claims Act can be subject to civil monetary penalties ranging from $5,000 to $10,000 for each false claim submitted to the United States government or its contactors, including state Medicaid agencies. The federal False Claims Act contains a "qui tam" or whistleblower provision to encourage individuals to report misconduct involving false claims. The qui tam provision allows any person with actual knowledge of allegedly false claims to the government to file a lawsuit on behalf of the U.S. government.

The False Claims Act protects individuals who report under the qui tam provisions from retaliation that results from filing an action under such Act, investigating a false claim, or providing testimony for or assistance in a federal False Claims Act action. The object of the False Claims Act is to prevent and detect fraud, waste, and abuse. HMO, Provider and its Professional Staff shall comply with the False Claims Act to the extent applicable and assist in the detection and prevention of fraud, waste, and abuse in connection with the provision of services under the Agreement and the Medicaid Contract.

34. Provider agrees and shall cause each member of its Professional Staff to agree that all records pertaining to the provision of Covered Medical Services under this Addendum be maintained for a period not less than ten (10) years from the close of the Medicaid Contract, and retained further if the records are under review or audit until the review or audit is complete. Prior approval for the disposition of records must be requested and approved by HMO if the Agreement is continuous.

35. Provider shall and shall cause each member of its Professional Staff to submit timely, accurate and complete encounter data to HMO.

36. Provider shall and shall cause each member of its Professional Staff to comply with HIPAA privacy and security requirements.

37. If Copayments are waived as an expanded benefit, Provider shall not charge Medicaid Members Copayments for Covered Medical Services; and if Copayments are not waived as an expanded benefit that the amount paid to Providers shall be the contracted amount, less any applicable Copayments.

38. HMO acknowledges that no subcontract HMO enters into with respect to performance under the Medicaid Contract shall, in any way, relieve HMO of any responsibility for the performance of duties under the Medicaid Contract. Furthermore, HMO shall assure that all tasks related to a subcontract related to the Medicaid Contract are performed in accordance with the terms of the Medicaid Contract and shall provide the AHCA Bureau of Managed Health Care with HMO's monitoring schedule annually by December 1. Provider will cooperate with HMO's monitoring schedule. HMO will identify any aspect of service that may be further subcontracted.

39. HMO shall make payment to Provider and all subcontractors pursuant to all applicable state and federal laws, rules and regulations, specifically Sections 409.967, 409.975(6), 409.982, and 641.3155, Florida Statutes, 42 CFR 447.46, and 42 CFR 447.45(d)(2),(3),(5), and (6).

40. If Provider is a nursing facility or hospice, Provider shall establish and follow a bed hold days policy that comports with Medicaid FFS bed hold days policies and procedures.

41. If Provider is a long term care facility, Provider shall develop and maintain policies and procedures for back-up plans in the event of absent employees, shall maintain sufficient staffing levels to ensure that service delivery is not interrupted due to absent employees.

42. If Provider is a residential facility, Provider shall collect patient responsibility in accordance with the terms and conditions of this Agreement, HMO's Provider Handbook and the Medicaid Contract. Provider shall not assess late fees.

43. If Provider is an assisted living facility or adult family care homes, Provider shall conform to the Home and Community-Based (HCB) characteristics pursuant to the Medicaid Contract and Provider will support the enrollee's community inclusion and integration by working with the case manager and enrollee to facilitate the enrollee's personal goals and community activities.

    Enrollees residing in Provider's Service Delivery Site shall be offered services with the following options unless medical, physical, or cognitive impairments restrict or limit exercise of these options.
    Choice of:
    - Private or semi-private rooms;
    - Roommate for semi-private rooms;
    - Locking door to living unit;
    - Access to telephone and length of use;
    - Eating schedule; and
    - Participation in facility and community activities.

    Ability to have:
    - Unlimited visitation; and
    - Snacks as desired.

    Ability to:
    - Prepare snacks as desired; and
    - Maintain personal sleeping schedule.

44. If Provider is an assisted living facility, Provider hereby agrees to accept monthly payments from HMO for enrollee services as full and final payment for all Long-term Care services detailed in the enrollee's plan of care which are to be provided by Provider. Enrollees remain responsible for the separate ALF room and board costs as detailed in their resident contract. As enrollees age in place and require more intense or additional Long-term Care services, Provider may not request payment for new or additional services from an enrollee, their family members or personal representative. Provider may only negotiate payment terms for services pursuant to this Agreement with HMO.

45. If Provider is a nursing facility or hospice, Provider shall maintain active Medicaid enrollment and submit required cost reports to AHCA for the duration of the Medicaid Contract.