MEDICARE ADVANTAGE COMPLIANCE LANGUAGE

The regulations governing the Medicare Advantage program set forth required terms for both Medicare Advantage plans and contracted providers. In order to make contracted providers aware of such terms, the Centers for Medicare & Medicaid Services ("CMS") has created a contracting checklist for Medicare Advantage plans to follow in developing providers' contracts and related policies and procedures. That checklist is included in Chapter 11 of the CMS Medicare Managed Care Manual (Section 100.4), a copy of which is available on the CMS website.

In certain cases, regulatory language must be included in the actual contractual document governing the relationship between the Medicare Advantage plan and the provider. In other cases, CMS allows a Medicare Advantage plan to include required terms in its policies and procedures that are made available to contracted providers.

The provisions that follow are required Medicare Advantage compliance terms included in the Highmark BCBSD, Inc. policies and procedures. Provider is required to comply with all such provisions, including, but not limited to, taking all necessary actions as may be specifically noted or such actions as may be required and requested by Highmark BCBSD in order for Highmark BCBSD to meet its obligations as a Medicare Advantage plan. All requirements set forth in this document shall apply to all Medicare Advantage plans, including Highmark BCBSD.

(1) Provider will safeguard the privacy of any information that identifies a particular member and will, and acknowledges that Highmark BCBSD has procedures to maintain records in an accurate and timely manner. Pursuant to 42 C.F.R. § 422.118, or its successor, the following shall apply: (a) Highmark BCBSD must establish and maintain procedures to, and Provider must, abide by all Federal and State laws regarding confidentiality and disclosure of medical records, or other health and enrollment information; (b) Highmark BCBSD and Provider must safeguard the privacy of any information that identifies a particular member; (c) Highmark BCBSD must establish and maintain procedures, and Provider must comply with the procedures that specify, (i) for what purposes the information will be used within the organization and (ii) to whom and for what purposes it will disclose the information outside the system; (d) Highmark BCBSD must establish and maintain procedures to, and Provider must, ensure that medical information is released only in accordance with Federal or State law, or pursuant to court orders or subpoenas; (e) Highmark BCBSD must establish and maintain procedures to, and Provider must, maintain records and information in an accurate and timely manner; and (f) Highmark BCBSD must establish and maintain procedures to, and Provider must, ensure timely access by Medicare Advantage members to the records and information that pertain to them. (Required by 42 C.F.R. § 422.118 or its successor).

(2) Highmark BCBSD may offer benefits in a continuation area for those members who move permanently "out of area." (Required by 42 C.F.R. § 422.54(b) or its successor).

(3) Provider will not deny, limit or condition the furnishing of a service to a member, and Highmark BCBSD will not deny, limit or condition the coverage or furnishing of benefits to an individual eligible to enroll in Highmark BCBSD's Medicare Advantage plan(s), on the basis of any factor that is related to health status, including, but not limited to, the

following: (a) medical condition, including mental as well as physical illness; (b) claims experience; (c) receipt of health care; (d) medical history; (e) genetic information; (f) evidence of insurability, including conditions arising out of acts of domestic violence; and (g) disability. (Required by 42 C.F.R. § 422.110(a) or its successor).

(4) Highmark BCBSD will make timely and reasonable payment to or on behalf of the member for emergency and urgently needed services obtained by a member from a non-contracted provider or supplier as provided in 42 C.F.R. § 422.100(b)(1)(ii) or its successor. (Required by 42 C.F.R. § 422.100(b)(1)(ii) or its successor).

(5) Highmark BCBSD will make timely and reasonable payment for renal dialysis provided by a non-contracted provider while a member is temporarily outside Highmark BCBSD's service area. (Required by 42 C.F.R. § 422.100(b)(1)(iv) or its successor).

(6) Highmark BCBSD provides Members with direct access (through self referral) to mammography screening and influenza vaccine. (Required by 42 C.F.R. § 422.100(g)(1) or its successor).

(7) Highmark BCBSD will not impose, and Provider will not collect any, cost-sharing on members for influenza and pneumococcal vaccines. (Required by 42 C.F.R. § 422.100(g)(2) or its successor).

(8) Highmark BCBSD does and will maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to meet the needs of the member population served. (Required by 42 C.F.R. § 422.112(a)(1) or its successor).

(9) Highmark BCBSD gives members who are women direct access to a women's health specialist within its provider network for routine and preventive services provided as basic benefits. (Required by 42 C.F.R. § 422.112(a)(3) or its successor).

(10) Highmark BCBSD must ensure that (a) the hours of operation of its contracted providers are convenient to the members served and do not discriminate against Medicare enrollee; and (b) plan services are available 24 hours a day, 7 days a week, when medically necessary. (Required by 42 C.F.R. § 422.112(a)(7) or its successor). As applicable, Provider will maintain business hours and/or ensure Provider's services are available in accordance with the preceding requirements.

(11) Highmark BCBSD must adhere to the CMS marketing provisions contained in 42 C.F.R. § 422.80(a), (b) and (c), or its/their successor(s).

(12) Highmark BCBSD must 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. (Required by 42 C.F.R. § 422.112(a)(8) or its successor).

(13) Highmark BCBSD must ensure continuity of care and integration of services through arrangements to include procedures to ensure that members are informed of specific health care needs that require follow-up and receive, as appropriate, training in self-

care and other measures that members may take to promote their own health. (Required by 42 C.F.R. § 422.112(b)(5) or its successor). As applicable, Provider will comply with these procedures.

(14) Highmark BCBSD has written policies regarding the implementation of advance directive rights, including, but not limited to, a statement that providers shall document in a prominent place in the applicable Member's medial record if the Member has executed an advance directive. (Required by 42 C.F.R. § 422.128(b)(1)(ii)(E) or its successor). Provider will comply, as applicable, with that policy.

(15) Highmark BCBSD's contract with CMS must contain a provision that it will provide all benefits covered by Medicare, and Provider must render services, in a manner consistent with professionally recognized standards of health care. (Required by 42 C.F.R. § 422.504(a)(3)(iii) or its successor).

(16) Highmark BCBSD must provide, and Provider shall comply with all, policies and procedures and contractual requirements providing for continuation of member health care benefits (a) for all members, for the duration of the contract period for which CMS payments have been made; and (b) for members who are hospitalized on the date Highmark BCBSD terminates, or in the event of insolvency, through discharge. Such requirements may be met in any manner as described in 42 C.F.R. § 422.504(g)(3) or its successor. (Required by 42 C.F.R. § 422.504(g)(2)(i) and (ii), and § 422.504(g)(3) or its/their successor(s)).

(17) All provider payment and incentive arrangements must be specified in the contractual arrangement between Highmark BCBSD and Provider. (Required by 42 C.F.R. § 422.208 or its successor).

(18) The payments that Provider receives from Highmark BCBSD for covered services rendered to members enrolled in a Medicare Advantage are, in whole or part, from federal funds and, and therefore, Provider and Highmark BCBSD are subject to certain laws as applicable to individuals and entities receiving federal funds. (Required by 42 C.F.R. § 422.504(h) or its successor).

(19) Highmark BCBSD is required to disclose information to members in the manner and the form prescribed by CMS as required under 42 C.F.R. §422.111. (Required by 42 C.F.R. § 422.504(a)(4) or its successor).

(20) Highmark BCBSD is required to disclose all information that is necessary for CMS to administer and evaluate Highmark BCBSD's Medicare Advantage program(s) and to simultaneously establish and facilitate a process for current and prospective members to exercise choice in obtaining Medicare services. (42 C.F.R. § 422.64(a) and § 422.504(f)(2) or its/their successor(s)). Such information includes, but is not limited to, plan quality and performance indicators for the benefits under Highmark BCBSD's Medicare Advantage program(s) including (a) disenrollment rates for members electing to receive benefits under such program for the previous two years, 42 C.F.R. § 422.504(f)(2)(iv)(A) or its successor; (b) information on member satisfaction, 42 C.F.R. § 422.504(f)(2)(iv)(B) or its successor; and (c) information on health outcomes, 42 C.F.R. § 422.504(f)(2)(iv)(C) or its successor. As required and/or requested, Provider will

cooperate with Highmark BCBSD and CMS in providing any of the preceding information that is under its control and/or in its possession.

(21) Highmark BCBSD must make a good faith effort to provide notice of termination of a contracted Provider at least 30 calendar days before the termination of the effective date to all members who are patients seen on a regular basis by the applicable Provider whose contract is terminating (which in the case of a primary care provider, means all members who are patients of such provider), irrespective of whether the termination was for cause or without cause. (Required by 42 C.F.R. § 422.111(e) or its successor).

(22) Highmark BCBSD must comply with reporting requirements in 42 C.F.R. § 422.516, or its successor, and 42 C.F.R. § 422.504(l)(2) & (l)(3), or its/their successor(s), for submitting and certifying data to CMS. Provider will certify the accuracy, completeness and truthfulness of all data that Highmark BCBSD is obligated to submit to CMS. (Required by 42 C.F.R. § 422.504(a)(8), or its successor, and § 422.504(l)(2) & (l)(3) or its/their successor(s)). As required and/or requested, Provider will further cooperate with Highmark BCBSD and CMS in providing any of the preceding information that is under its control and/or in its possession.

(23) Highmark BCBSD must establish a formal mechanism to consult with the physicians who have agreed to provide services under Highmark BCBSD's Medicare Advantage program(s), regarding Highmark BCBSD's medical policy, quality assurance programs and medical management procedures and ensure that the following standards are met: (a) practice guidelines and utilization management guidelines are – (i) based on reasonable medical evidence or a consensus of health care professionals in the particular field; (ii) consider the needs of the enrolled population; (iii) are developed in consultation with contracted physicians; and (iv) are reviewed and updated periodically; (b) decisions with respect to utilization management are communicated to providers and, as appropriate, to members; and (c) decisions with respect to utilization management, member education, coverage of services, and other areas to which guidelines apply are consistent with such guidelines. (Required by 42 C.F.R. § 422.202(b) or its successor). In addition, Highmark BCBSD must operate a quality assurance and performance improvement program and have an agreement for external quality review as required by 42 C.F.R. Subpart D or its successor. (Required by 42 C.F.R. § 504(a)(5) or its successor). Provider shall cooperate with all such medical policy, medical management procedures and quality assurance and performance improvement programs.

(24) Highmark BCBSD must give a physician written notice of the following when and if Highmark BCBSD suspends or terminates an agreement under which the physician provides services to members. The written notice must include the following: (a) the reasons for the action, including, if relevant, the standards and profiling data used to evaluate the physicians and numbers and mix of physicians needed to maintain an adequate network; and (b) the affected physician's right to appeal the action and the process and timing for requesting a hearing. (Required by 42 C.F.R. § 422.202(d)(1) or its successor).

(25) Any without cause termination by Highmark BCBSD or Provider requires at least sixty (60) days prior written notice. (Required by 42 C.F.R. § 422.202(d)(4) or its successor).

(26) Highmark BCBSD and Provider must comply with Federal laws and regulations designed to ameliorate fraud, waste, and 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 (42 U.S.C. § 1320a-7b(b)). (Required by 42 C.F.R. § 422.504(h)(1) or its successor).

(27) Highmark BCBSD and Provider may not employ or contract with an individual (which in the case of Highmark BCBSD includes, as applicable, Provider) who is excluded from participation in Medicare under section 1128 or 1128A of the Social Security Act, or with an entity (which in the case of Highmark BCBSD includes, as applicable, Provider) that employs or contracts with such an individual, for the provision of any of the following: (a) health care; (b) utilization review; (c) medical social work; and/or (d) administrative services. (Required by 42 C.F.R. § 422.752(a)(8) or its successor).

(28) Highmark BCBSD has established and will maintain (a) a grievance procedure as described in 42 C.F.R. § 422.564, or its successor, for addressing issues that do involved organization determinations; (b) a procedure for making timely organization determinations; and (c) appeal procedures that meet the requirements of this subpart for issues that involve organization determinations. Highmark BCBSD must ensure that all members receive notification about the (a) grievance and appeal procedures that are available to them; and (b) complaint process available to the member under the QIO process as set forth under 1154(a)(14) of the Social Security Act. (Required by 42 C.F.R. § 422.562(a) or its successor). Provider will comply with Medicare requirements regarding Member grievances, appeals, and complaints and will cooperate with Highmark BCBSD in meeting its obligations to include, but not be limited to, the gathering and forwarding of information in a timely manner as well as compliance and adherence to any decisions rendered.

(29) Provider shall comply with federal laws and regulations designed to prevent, detect and correct Fraud, Waste, and Abuse, including applicable provisions of federal criminal law, the False Claims Act (31 U.S.C. § 3729 et seq., as amended by the Patient Protection and Affordable Care Act of 2010), any False Claims Act that applies to customer, and the Anti-Kickback statute (42 U.S.C. § 1320a-7b(b)), 42 C.F.R. §§ 422.503(b)(4)(vi), 422.504(h)(1), 423.505(h)(1). For purposes of this Section, Abuse, Fraud, and Waste are defined as follows:

(A) "Abuse" shall mean actions that may, directly or indirectly, result in: unnecessary costs to the Medicare Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment.

(B) "Fraud" shall mean knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C. § 1347).

(C) "Waste" shall mean the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program.