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Carelon Behavioral Health
Medicare Advantage Provisions – Appendix 4

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1. Medicare Advantage Provisions

The Centers for Medicare and Medicaid Services (CMS) implementing regulations and associated rules applicable to Medicare Advantage (MA) plans require that certain issues are addressed either in contracts with first-tier contractors and/or in policies and procedures or manuals.

This Appendix contains additional provisions applicable to covered services rendered to MA Members (as defined below) covered under MA Plans (as defined below) offered and/or administered by Carelon Behavioral Health, Inc. In the event of any conflict between the provisions of the provider agreement, the handbook, and this Appendix, the provisions of this Appendix control as related to services rendered to MA Members.

1.01 Definitions

TERM	DEFINITION
Centers for Medicare and Medicaid Services (CMS)	The agency within the Department of Health and Human Services that administers the Medicare and Medicaid programs.
Completion of Audit	Completion of audit by the Department of Health and Human Services, the Government Accountability Office, or their designees of a Medicare Advantage Organization (MAO), MAO contractor or related entity.
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 MAO (or applicant) and a first-tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
Final Contract Period	The final term of the contract between CMS and the MAO.
First Tier Entity	Any party that enters into a written arrangement, acceptable to CMS, with an MAO 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 (MAO)	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.
MA Plan	One or more plans in the MA program offered or administered by an MAO and covered under the MAO's contract with Carelon.

Member, Enrollee, Medicare Beneficiary	A Medicare Advantage eligible individual who has enrolled in or elected coverage through an MAO.
Provider	• Any individual who is engaged in the delivery of health care services in a state and is licensed by the state to engage in that activity in the state • Any entity that is engaged in the delivery of health care 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 MAO by common ownership and: 1. Performs some of the MAO's management functions under contract or delegation 2. Furnishes services to Medicare enrollees under an oral or written agreement Leases real property or sells materials to the MAO at a cost of more than $2,500 during a contract period

1.02 Required Provisions

The provider agrees to the following:

1. **Record Retention and Audit Rights**

   The provider agrees to retain any books, contracts, records and documents related to the MAO's contract with CMS for a period of ten years from the final date of the contract period or the completion of any audit, whichever is later. The provider agrees to comply with any document requests by the MAO pursuant to an audit or to monitor the provider's compliance with the terms of the Agreement or this Appendix. The provider will provide these documents to Plan without charge. [42 CFR §§ 422.503(b)(4)(vi)(F) and 422.504(d), 422.504(e)(2)]. HHS, the Comptroller General, or their designees have the direct 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 MAO through 10 years from the final date of the final contract period of the contract entered into between CMS and the MA O or from the date of completion of any audit, whichever is later. [42 C.F.R. §§ 422.504(i)(2)(i) and (ii).

2. **Confidentiality**

   The provider will comply with the confidentiality and enrollee record accuracy requirements, including:

   - Abiding by all federal and state laws regarding confidentiality and disclosure of medical records, or other health and enrollment information
   - Ensuring that medical information is released only in accordance with applicable federal or state law, or pursuant to court orders or subpoenas
   - Maintaining the records and information in an accurate and timely manner
   - 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]

3. **Beneficiary Protections**

   Enrollees will not be held liable for payment of any fees that are the legal obligation of the MAO. When referring an MA member to another provider/facility, selecting a contracted provider within Carelon's/the MA Plan's Medicare network will maximize the member's benefit and minimize their out-of-pocket expenses. Call Provider Services for assistance. If you believe you must refer to a provider outside of the network, you must contact Carelon in advance for an organization determination to be made. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)]

4. **Advance Directives and Patient Rights**

   Providers must comply with 42 C.F.R. § 422.128 by informing Medicare Advantage members of their rights, including the right to make advance directives. This includes documenting whether or not the member has executed an advance directive and educating staff on honoring these rights.

5. **Cultural Competency & Nondiscrimination**

   Providers must comply with Section 1557 of the Affordable Care Act and 42 C.F.R. §§ 422.112(a)(8).

   This includes ensuring services are delivered in a culturally and linguistically appropriate manner, providing translated materials when required, and accommodating the communication needs of individuals with disabilities and limited English proficiency.

6. **Dual Eligible Beneficiary Protections**

   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. Providers 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:

- Accept the MA plan payment as payment in full, or
- Bill the appropriate State source

[42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)

7. **Compliance with MAO's Contractual Provisions**

Any services or other activity performed in accordance with a contract or written agreement by the provider are consistent and comply with the MAO's contractual obligations. [42 C.F.R. § 422.504(i)(3)(iii)]. Providers must submit diagnosis code data that is accurate, complete and truthful (based on their best knowledge, information and belief). Data should be submitted through a compliant, electronic 837 submission or on a CMS-1500/UB-04 form.

8. **Business Continuity and Disaster Recovery**

Providers must maintain a business continuity and disaster recovery plan to ensure ongoing service delivery and preservation of medical records and other essential data.

This includes protocols for emergency preparedness and response in alignment with CMS expectations.

9. **Exclusion/Debarment Screening**

The provider agrees to:

- Screen any prospective, potential or actual new employee, volunteer, consultants, or governing body member prior to hire or contract, and monthly thereafter against the List of Excluded Individuals and Entities (LEIE), Excluded Parties List Service (EPLS), the CMS Preclusion List, and excluded individuals posted by the OMIG on its website
- Disclose immediately to Carelon Behavioral Health all exclusions and events that would make them ineligible to perform work related, directly or indirectly, to federal programs
- Immediately remove such a person from any work related directly or indirectly to any federal healthcare program

The provider certifies that as of the date of this Appendix, neither it nor any of its employees, volunteers, consultants or governing body members are currently so excluded and that it maintains full participation status in the federal Medicare program. [42 C.F.R. 422.224]

10. **Prompt Payment Provisions**

    Contracts or other written agreements between the MAO 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 MAO or Carelon Behavioral Health is obligated to pay contracted providers under the terms of the contract between Carelon Behavioral Health and the provider. [42 C.F.R. §§ 422.520(b)(1) and (2)]. The prompt payment provision is set forth is set forth in Exhibit D. Payment section under Article 6 of the Agreement.

11. **Compliance with Medicare Laws, Regulations and CMS Instructions**

    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)]

12. **Accountability Provisions**

    If any of Carelon Behavioral Health's activities or responsibilities under its contract with the MAO are sub-delegated to the provider in the Agreement, such as a provider performing credentialing functions, the following provisions shall apply:

    - The delegated activities and reporting responsibilities shall be specified in the Agreement
    - Carelon Behavioral Health and MAO each reserves the right to revoke the delegation activities and reporting requirements or to specify other remedies in instances where Carelon Behavioral Health or the MAO determines that the provider has not performed satisfactorily.
    - Carelon Behavioral Health and MAO each retain the right to monitor the performance of the provider on an ongoing basis.
    - Carelon Behavioral Health and the MAO each retain the right to: review the credentials of medical professionals affiliated with the provider; review and approve the credentialing process; and audit the credentialing process on an ongoing basis.
    - If Carelon Behavioral Health delegates the selection of providers, contractors, or subcontractors, Carelon Behavioral Health and the MAO each retain the right to approve, suspend, or terminate any such arrangement.

      [42 C.F.R. §§ 422.504(i)(4) and (5)]

13. **Training and Reporting**

The provider agrees to take any required training. MA Plans have a model of care program in place for members of Special Needs Plans (SNPs). SNP model of care (MOC) training is required annually and available via the format designated by each MA Plan (e.g., learning management system, survey, or the MA Plan's provider website). The provider will take fraud, waste and abuse (FWA) training unless the provider is deemed to have met this requirement as a result of enrollment in Medicare. Required FWA training is developed and provided by CMS and is available through the CMS Medicare Learning Network. In addition, effective January 1, 2016, providers are required to take CMS general compliance program training through the Medicare Learning Network. [79 Fed. Reg. at 29853-5, 29958-59). Both trainings must occur within ninety (90) days of initial hiring and annually thereafter. [42 C.F.R. §§ 422.503(b)(4)(vi)(C)]. The provider must maintain documentation sufficient to demonstrate that the provider fulfilled the required training. [Medicare Managed Care Manual, Chapter 21, § 50.3.2, 42 CFR §§§§ 422.503(b)(4)(vi)(A) & (C), 422.504(b)(4)(vi)(A) & (F)].

The provider agrees to report compliance or FWA concerns to CMS, the MAO or Carelon Behavioral Health. Reports of suspected fraud, waste, abuse, or other compliance concerns must be submitted within five business days of discovery. Providers may use Carelon's designated compliance hotline at 888-293-3027., secure web forms, or direct contacts to submit such reports.

14. **Payment**

Regardless of any provision to the contrary, to the extent an MA member receives covered services from provider on an out-of-network basis and/or there is no specific Rate Schedule (Appendix A) for that member's MA Plan attached to this Agreement, maximum payment for any covered services rendered to such MA member is limited to the lesser of one hundred percent (100%) of Medicare allowable or the amount provided for under applicable MA laws, rules and/or regulations applicable to the member's MA Plan and is subject to the terms of the member's MA plan.

15. **Appeals and Grievances**

Providers shall cooperate with the MAO's processes related to coverage determinations, appeals, and grievances in accordance with 42 C.F.R. §§ 422.562–422.576. This includes timely submission of information and participation in case discussions or resolution processes when requested.

16. **Termination**

    1. In addition to the provisions set forth in the Agreement, this Appendix may be suspended or terminated by Carelon Behavioral Health as to any one or more MAO's MA Plans immediately upon written notice if:

        a. An MAO's Medicare contract is suspended or terminated for any reason.

        b. The provider is disqualified, terminated, suspended, debarred, or otherwise excluded/precluded from or ineligible for participation under the MA program or any other state or federal government-sponsored program.

        c. The Agreement is terminated or not renewed.

    2. Following expiration or termination (whether due to insolvency or cessation of operations of Carelon Behavioral Health or a given MAO) of the Agreement, an otherwise-eligible provider will continue to provide covered services to MA members. However, providers who are ineligible for participation in Medicare cannot continue treating MA members.

        a. For those MA members confined in an inpatient facility on the date of expiration or termination until their discharge.

        b. For all MA members through the period for which payments have been made by CMS to the applicable MAO under its Medicare contract.

            For those MA members in active treatment of chronic or acute behavioral health or substance use disorder conditions as of the date of expiration or termination of the Agreement through their current course of active treatment not to exceed 90 days unless otherwise require by subsection (b) above. The terms and conditions of the Agreement apply to such post-expiration or post-termination covered services. Payment for covered services rendered to MA members post expiration or post-termination of this Agreement will be the fee- for-service rates set out in the applicable Rate Schedule, less any MA member copayments. [42 CFR, §§ 422.202(d) and 422.224]

17. **Conflict of Interest**

    The provider agrees to comply with MAO's Conflict of Interest Policy or its own Conflict of Interest Policy that complies with CMS requirements. The provider will require its governing body, officers, and senior leadership (as applicable) to sign a conflict of interest at the time of hire and annually thereafter certifying that they are free from any conflict of interest related to Medicare. [42 C.F.R. §§ 422.503(b)(4)(vi)(A)(3), 423.504(b)(4)(vi)(A)(3)].

18. **Flow Down Provision**

    The provider shall incorporate the terms of this Appendix into any and all subcontracts entered into delegating any of the provider's obligations under the Agreement or Addendum. Providers are responsible for ensuring subcontractor compliance with all provisions of this Appendix. Providers must maintain documentation of such oversight and acknowledge that Carelon and the MAO retain the right to audit subcontractor performance at any time.

19. **Reporting Support**

    The provider shall maintain and provide to Carelon Behavioral Health any data, information, books, contracts, records and other documentation relating to medical costs, drug costs, quality improvement activities, claims adjudication services, and any other activity identified by Carelon Behavioral Health or the MAO with which Carelon Behavioral Health contracts that relate to the MAOs' medical loss ratio reporting for a contract year under Federal laws and regulations. The provider shall comply with this section for the time period required by §§ 422.2480(c) and 423.2480(c).

20. **Other Support**

    The provider shall provide any other assistance reasonably requested by the MAO or Carelon Behavioral Health in support of the MAO's contract with CMS or as required by law. If the MA Plan is selected by CMS to participate in a contract-specific Risk Adjustment Data Validation (RADV) audit, the plan and the providers that treated the MA members included in the audit will be required to submit medical records for the diagnosis codes included in the audit sample. The medical records will be used by CMS to assess if the diagnosis data is supported by the medical record, an important CMS requirement.

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