

HEALTH INSURANCE BENEFITS FOR THE AGED AND DISABLED
(Contract with Eligible Organization Pursuant to
Section 1876 of the Social Security Act)

CONTRACT (<<CONTRACT_ID>>)

Between

The Secretary of the Department of Health and Human Services, who has delegated authority
to the Administrator of the Centers for Medicare and Medicaid Services, hereinafter referred
to as CMS
and

<<CONTRACT_NAME>>
(hereinafter referred to as the Cost Plan)

CMS and the Cost Plan, an organization which provides medical and other health services (or
arranges for their availability) on a prepayment basis, agree to the following as called for under
42 CFR Part 417, subparts J through R, and for the purposes of §1876 of the Social Security Act:

Article I

Term of Contract

The contract shall begin on the date of signature by CMS's authorized representative through December 31, 2023. The contract will be renewed for successive periods of one year unless the Organization or CMS gives written notice of intention not to renew the contract at least 90 days before the end of the current period. (Additional requirements concerning nonrenewal of contracts, binding on both CMS and the Organization, may be found at 42 CFR §417.492.) If the Cost Plan had a contract with CMS for Contract Year 2022 under the contract ID number designated above, this document is considered a renewal of the existing contract. While the terms of this document supersede the terms of the 2022 contract, the parties' execution of this contract does not extinguish or interrupt any pending obligations or actions that may have arisen under the 2022 or prior year contracts.

Organizations offering Part D benefits also must execute a contract addendum Pursuant to §§ 1860D-1 through 1860D-42 of the Social Security Act for the Operation of a Voluntary Medicare Prescription Drug Plan (hereafter the "Part D Addendum"). For Organizations offering Cost-PD plans, the Part D Addendum governs the rights and obligations of the parties relating to the provision of Part D benefits, in accordance with its terms, as of its effective date.

Article II

Payment Method

The Organization will receive payment under this contract on a reasonable cost basis under §1876(h) of the Act and its implementing regulations at 42 CFR §§417.524-417.576, and subject to the provisions of Article VI. The method of payment for hospitals and skilled nursing facilities (SNF) in 2022 will be the payment method used in 2023 unless CMS is otherwise notified.

Article III

Geographic Area

The Organization agrees that the contract shall be effective for the geographic area described in the attachment to this contract. (Modifications to the geographic area during the period of the contract are governed by Article VI.)

Article IV

General Conditions

- A. The Organization agrees to comply with the law, regulations, and general instructions of the Centers for Medicare and Medicaid Services (CMS) concerning the participation in Medicare of health maintenance organizations (HMOs) and competitive medical plans (CMPs) reimbursed on a cost basis.
- B. As part of its ongoing quality improvement program:

1. The Organization agrees to comply with the requirements for Quality Improvement Organization (QIO) review of services furnished to Medicare enrollees as set forth in 42 CFR Part 417 Subpart D and required by 42 CFR §417.478(a).
2. The Organization shall furnish to the QIO requested on-site access to or copies of patient care records and other pertinent data, and permit the QIO or its subcontractor to examine its operations and records as necessary for the QIO to carry out its functions under the Act.

C. The Organization agrees to comply with:

1. Sections 1318(a) and (c) of the Public Health Service Act which pertain to disclosure of certain financial information;
2. Sections 1301(c)(1) and (c)(8) of the Public Health Service Act, which relate to fiscal, administrative, and management requirements and liability arrangements to protect all members of the organization; and to notify CMS 60 days prior to any changes in its insolvency arrangements; and
3. The reporting requirements in 42 CFR §417.126(a) which pertain to the monitoring of an organization's continued compliance. For purposes of this paragraph, references in that section to an "HMO" are also deemed references to a "CMP."
4. Comply with the prohibitions, procedures and requirements related to payment to an individual or entity on the preclusion list, as defined and described in 42 CFR §§ 422.2, 422.222 and 422.224. For purposes of this paragraph, references in 42 CFR §§ 422.2, 422.222 and 422.224 to an MA organization or MA plan are deemed to be references to an HMO or CMP, references to sanctions are deemed to be references to 42 CFR § 417.500, and references to termination are deemed to be references to 42 CFR §§ 417.492-417.494. [42 CFR §417.478]

D. The Organization agrees to comply with applicable anti-discrimination laws, including Title VI of the Civil Rights Act of 1964 (and pertinent regulations at 45 CFR Part 80), §504 of the Rehabilitation Act of 1973 (and pertinent regulations at 45 CFR Part 84), and the Age Discrimination Act of 1975 (and pertinent regulations at 45 CFR Part 91). The MA Organization agrees to comply with the requirements relating to Nondiscrimination in Health Programs and Activities in 45 CFR Part 92, including submitting assurances that the MA Organization's health programs and activities will be operated in compliance with the nondiscrimination requirements, as required in 45 CFR §92.4.

E. The Organization agrees to the following in accordance with 42 CFR §417.482:

1. CMS may evaluate, through inspection or other means, the quality, appropriateness, and timeliness of services furnished under the contract to the Organization's Medicare enrollees;

2. CMS may evaluate, through inspection or other means, the facilities of the organization when there is reasonable evidence of some need for that inspection;
 3. CMS, the Comptroller General, or their designees may audit or inspect any books and records of the organization or its transferee that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under the contract;
 4. CMS may evaluate, through inspection or other means, the enrollment and disenrollment records for the current contract period and three prior periods, when there is reasonable evidence of some need for that inspection;
 5. The Organization will make available, for the purposes specified in section E of this Article, its premises, physical facilities, and equipment, its records relating to its Medicare enrollees, the records specified in 42 CFR §417.480, and any additional relevant information that CMS may require.
 6. The right to inspect, evaluate, and audit, will extend through three years from the date of the final settlement for any contract period unless -
 - (a) CMS determines there is a special need to retain a particular record or group of records for a longer period and notifies the Organization at least 30 days before the normal disposition date;
 - (b) There has been a termination, dispute, fraud, or similar fault by the Organization, in which case the retention may be extended to three years from the date of any resulting final settlement; or
 - (c) CMS determines that there is a reasonable possibility of fraud, in which case it may reopen a final settlement at any time.
- F. The Organization shall submit to CMS (in such form and detail as the CMS shall prescribe in regulations and general instructions), at least the following information and reports in accordance with 42 CFR §§ 417.572, and 417.576:
1. Data pertaining to health insurance claim numbers from beneficiaries, which shall be transmitted initially and on a continuing basis, as required to annotate the relevant CMS data files;
 2. Statistical data on provider services and on medical and other services;
 3. Enrollment and actuarial data; and
 4. Any other reports or data that CMS may require.

- G. The Organization agrees to report all enrollments, disenrollment, and other beneficiary characteristic records according to CMS program instructions in accordance with 42 CFR §417.430. All records must be transmitted: 1) through an approved CMS systems contractor; or 2) over data transmission lines directly to CMS. All electronic transmissions must be totally compatible and consistent with the relevant CMS computer record systems.
- H. The Organization shall furnish to organizations serving as Medicare administrative contractors (MACs), carriers and intermediaries under Title XVIII, information necessary to allow the MACs, carriers or intermediaries to make proper payment under Title XVIII for Medicare beneficiaries enrolled in the Organization.
- I. The Organization agrees to require all entities related to the Organization, as determined under 42 CFR §417.484(a), to agree that -
1. CMS, the Comptroller General, or their designees have the right to inspect, evaluate, and audit any pertinent books, documents, papers, and records of the subcontractor involving transactions related to the subcontract; and
 2. The right under this section to information for any particular contract period will exist for a period equivalent to that specified in section E(6) of this Article.
 3. That payments must not be made to individuals and entities included on the preclusion list, defined in 42 CFR §422.2.
- J. The Organization agrees -
1. To submit to CMS -
 - (a) All financial and payment information required under 42 CFR §§417.530 through 417.576 and for final settlement; and
 - (b) Any other information necessary for the administration or evaluation of the Medicare program. **[417.486]**
 2. To comply with the requirements set forth in 42 CFR Part 420 Subpart C, pertaining to the disclosure of ownership and control information **[417.486]**;
 3. To comply with the requirements of the Privacy Act, as implemented by 45 CFR Part 5b and 42 CFR Part 401 Subpart B, with respect to any system of records developed in performing carrier or intermediary functions under 42 CFR §§417.532 and 417.533 **[417.486]**;
 4. To meet the confidentiality requirement of 42 CFR §482.24 for medical records and for all other information on enrollees, not covered under item 3 above, that is contained in its records or obtained from CMS or others **[417.486]**.

- K. The Organization shall provide and supply (1) full and complete information as to ownership of a subcontractor with whom such organization has had during the previous twelve months, business transactions in an aggregate amount in excess of \$25,000, and (2) full and complete information as to any significant business transactions during the five year period ending on the date of CMS's request, between the Organization and any wholly-owned supplier or between the Organization and any subcontractor. **[42 CFR §417.126(b).]**
- L. The Organization shall notify CMS of loans and other special financial arrangements which are made between the Organization and subcontractors, affiliates and related parties. **[417.486(a)(1), (b); Part 417 Subpart O; Part 420 Subpart C]**
- M. The Organization agrees that no marketing material may be distributed by an organization to (or for the use of) individuals eligible to enroll or enrolled in the organization under this contract unless at least 45 days before the distribution, the Organization has submitted the material to CMS for review, and CMS has not disapproved the distribution of the material. Where applicable, the Organization may use the file and use process described at Part 422 Subpart V. The Organization agrees to comply with the requirements set forth in 42 CFR Part 422 Subpart V and, for purposes of this paragraph, references in those regulations to an MA organization or MA plan are deemed to be references to an HMO or CMP and references to part 422 are deemed to be references to part 417. **[42 CFR 417.428]**
- N. The Organization agrees to allow eligible beneficiaries to enroll under this contract during any open enrollment period required by CMS through regulations. The Organization agrees to accept beneficiaries up to the limit of its capacity as approved by CMS. 42 CFR §417.413 (e).
- O. Upon termination of this contract, the Organization agrees:
1. To give its Medicare enrollees a written notice by mail of the termination at least 60 days before the termination date;
 2. To be responsible for the cost of the notice;
 3. To submit a copy of the notice to CMS for review.
[417.492, 417.494]
- P. The Organization shall comply with the requirements of Subpart M of 42 CFR Part 422, which govern organization determinations, grievances and appeals, with the exception of Part A services paid for directly by CMS. **[417.600]**
- Q. Effective after contract year 2018, where two or more Medicare Advantage local coordinated care plans or two or more Medicare Advantage regional plans enter the organization's service area and the conditions of §417.402(c) are met, the Organization understands that this contract will automatically be non-renewed for the overlapping portion of the service area. Thereafter, if the Organization wishes to continue to offer Medicare benefits to enrollees in that area, it will be required to comply with all requirements applicable to Medicare

Advantage plans under 42 CFR Part 422 and enter into a Medicare Advantage contract with CMS. This contract may continue to be in effect for any portion of the service area not meeting the conditions of §417.402(c). [**§ 1876(h)(5)(C) and 417.492(b)**].

- R. As part of advance directives requirements, the Organization agrees:
1. To inform all Medicare enrollees at the time of enrollment of their right (under State law whether statutory or recognized by the courts of the State) to accept or refuse treatment and to execute an advance directive, such as living wills or durable powers of attorney, and of the Organization's written policies on implementation of that right;
 2. To document in the individual's medical records whether or not an individual has executed an advance directive;
 3. To not condition treatment or otherwise discriminate on the basis of whether an individual has executed an advance directive;
 4. To comply with State law (whether statutory or recognized by the courts of the State) on advance directives; and
 5. To provide (individually or with others) for education for staff and the community on advance directives. [§ 1876(c)(7)]
- S. The Organization agrees to be rated under the quality rating system specified at subpart D of 42 CFR part 422, and for cost plans that provide the Part D prescription benefit, also under the quality rating system specified at 42 CFR part 423, subpart D. Cost contracts are not required to submit data or be rated on specific measures determined by CMS to be inapplicable to their contract or for which data are not available, including hospital readmissions and call center measures. [42 CFR §417.472(k)]
- T. The prohibitions, procedures, and requirements relating to payment to individuals and entities on the preclusion list, defined in 42 CFR §422.2, apply to the Organization. [42 CFR §417.478(e)]

Article V
Conditions of the Reasonable Cost Method of Payment

- A. CMS shall make payment under this contract for services rendered to Medicare enrollees on a reasonable cost basis as provided in CMS regulations. Notwithstanding the foregoing, to the extent that the Organization provides qualified prescription drug coverage to enrollees under Part D, costs related to the offering of Part D benefits are reimbursed solely under the applicable provisions of 42 CFR Part 423.
- B. The Organization agrees to maintain books, records, documents, and other evidence of accounting procedures and practices that -
 - 1. Are sufficient to -
 - (a) Ensure an audit trail; and
 - (b) Properly reflect all direct and indirect costs claimed to have been incurred under the contract; and
 - 2. Include at least records of the following:
 - (a) Ownership, organization, and operation of the Organization's financial, medical and other recordkeeping systems;
 - (b) Financial statements for the current contract period and three prior periods;
 - (c) Federal income tax or information returns for the current contract period and three prior periods;
 - (d) Assets acquisition, lease, sale, or other action;
 - (e) Agreements, contracts, and subcontracts;
 - (f) Franchise, marketing, and management agreements;
 - (g) Schedules of charges for the Organization's fee-for-service patients;
 - (h) Matters pertaining to costs of operations;
 - (i) Amounts of income received, by source and payment;
 - (j) Cash flow statements;
 - (k) Any financial reports filed with other Federal programs or State authorities.

- C. The Organization has the right to appeal any final determination of costs pursuant to the reimbursement appeals procedures contained in the regulations at 42 CFR Part 405, Subpart R. [417.576]
- D. The Organization shall make available for the purposes specified in paragraphs 1-4 of section E of Article IV, its premises, physical facilities, and equipment, its records relating to its Medicare enrollees, the records specified in 42 CFR §417.480, and any additional relevant information that CMS may require.
- E. The Organization agrees that -
 - 1. Consistent with 42 CFR Part 417 Subpart O, it will provide, subsequent to an accounting period, an independently certified financial statement of its per capita incurred cost, based on the types of components of expenses otherwise reimbursable under Title XVIII, for providing the Medicare services to which the enrollees are entitled, as described in 42 CFR Part 417, subparts J and L, including its method of allocating costs between individuals enrolled under this section and other individuals enrolled with the Organization, such statements to be provided in accordance with accounting procedures prescribed by CMS;
 - 2. Failure to report such information may be deemed evidence of likely overpayment upon which basis collection action may be taken.

Article VI

Modification, Termination or Non-renewal

This contract may be modified at any time by written consent of both the Organization and CMS. If the contract is modified, the Organization must notify its Medicare enrollees of any changes that CMS determines are appropriate for notification. This contract may be terminated by either party in accordance with the provisions of 42 CFR §417.494 or a decision by either party not to renew the contract may be made in accordance with the provisions of 42 CFR §417.492.

Article VII

Any revisions to applicable provisions of Title XI or Title XVIII of the Act, Title XIII of the Public Health Service Act, implementing regulations, policy issuances and instructions apply as of their effective date.

Article VIII

Miscellaneous

A. DEFINITIONS

Terms not otherwise defined in this contract shall have the meaning given to such terms in 42 CFR Part 417.

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B. ALTERATION TO ORIGINAL CONTRACT TERMS

The Organization agrees that it has not altered in any way the terms of this contract presented for signature by CMS. The Organization agrees that any alterations to the original text the Organization may make to this contract shall not be binding on the parties.

C. PLAN DISCLOSURE REQUIREMENTS

The procedures and requirements relating to disclosure in 42 CFR §422.111 apply to this contract in accordance with 42 CFR §417.427.

- D. The Organization agrees to comply with the requirements relating to Nondiscrimination in Health Programs and Activities in 45 CFR Part 92, including submitting assurances that the Organization's health programs and activities will be operated in compliance with the nondiscrimination requirements, as required in 45 CFR §92.4

<<CONTRACT_ID>>

In witness whereof, the parties hereby execute this contract.

This document has been electronically signed by:

FOR THE ORGANIZATION

<<CONTRACTING_OFFICIAL_NAME >>

Contracting Official Name

<<DATE_STAMP>>

Date

<<CONTRACT_NAME>>

Organization

<<ADDRESS>>

Address

FOR THE CENTERS FOR MEDICARE & MEDICAID SERVICES

<<KATHRYN COLEMAN_ESIG>>

Kathryn A. Coleman

Director

Medicare Drug and Health

Plan Contract Administration Group,

Center for Medicare

<<DATE_STAMP>>

Date

<<CONTRACT_ID>>