MEDICARE HMO ADDENDUM

This Medicare HMO Addendum to the Physician Services Agreement ("Addendum") is made effective as of ____ day of _____, 201_, by and between Mount Carmel Health Partners, Inc. ("Health Partners") and ("Physician").

Background Information

WHEREAS, Physician and Health Partners have entered into a certain Physician Services Agreement ("PSA"), as amended from time to time, for the provision by Physician of professional medical and related health care services to members of health benefit plans which contract with Health Partners;

WHEREAS, Plan offers a Medicare Advantage coordinated care plan ("Plan") through a contract with the Centers for Medicare and Medicaid Services ("CMS");

WHEREAS, as a condition of participating as a Physician with a Medicare Advantage organization offering a Medicare Advantage coordinate care plan, CMS requires Medicare Advantage organizations and Physicians to agree in writing to abide by pertinent provider contracting provisions of the Medicare Advantage program; and

WHEREAS, Physician wishes to provide professional medical and related health care services to members ("Members") of Plan in compliance with the Medicare Advantage Physician participation requirements set forth in this Addendum.

NOW, THEREFORE, in consideration of the above premises and covenants hereinafter set forth, it is hereby agreed by and between the parties as follows:

Agreement

1. Physician's books, contracts, documents, papers, medical records, patient care documentation, and any other records that pertain to any aspect of services performed for Members shall be maintained by Physician for ten (10) years or the date of completion of any federal or state government audit, whichever is later. Physician shall retain such records beyond such period upon direction from CMS or other government agency. Physician acknowledges and agrees that, as a contractor of Plan, Physician shall give Plan, the U.S. Department of Health and Human Services, the Comptroller General, the General Accounting Office, other federal agencies and state and local regulatory agencies and their designees the right to inspect, evaluate and audit any pertinent contracts, books, documents, papers and records involving any aspect of services performed for Members for a period of ten (10) years from the final date of the contract between CMS and Plan or the date of completion of an audit, whichever is later. Physician further agrees to provide direct access including on-site access, so that HHS, the Comptroller General, or their designees may conduct any such audit, inspection or evaluation as described in this section. The right to audit records of Plan and Physician may be extended if CMS determines there is a special need to retain a particular record or group of records for a longer period and notifies Plan or Physician at least thirty (30) days prior to the normal disposition date or if there is a reasonable possibility of fraud. Physician's obligations hereunder shall survive the termination or expiration of this Agreement. [42 CFR §§422.502(e)(2), (e)(3), (e)(4) and 422.502(i)(2)]

2. Plan and Physician shall safeguard the privacy of all information that identifies a particular Member and abide by all applicable federal and state laws and regulations regarding confidentiality and disclosure of mental health records, medical records, other health information and enrollment and Member information. Information from, or copies of, medical, enrollment and other records may be released only to authorized individuals in accordance with applicable federal and state laws and regulations. Plan shall secure a signed release from a Member prior to disclosure of the Member's medical records and health information. Plan and Physician shall take reasonable precautions to ensure that unauthorized individuals cannot gain access to or alter patient records. [42 CFR §422.118]

3. Member medical and other records shall be maintained by Physician in an accurate and timely manner and in accordance with accepted industry standards and applicable federal and state laws and regulations. Members shall be given timely access to their medical records and information that pertains to them. Any charges to Members for copies of records shall not exceed the reasonable and customary charges in the professional community. [42 CFR §422.118]

4. Neither Plan nor Physician shall discriminate, deny, limit or condition the coverage or furnishing of covered services to Members on the basis of any factor related to health status including, but not limited to, medical condition, including

mental and physical illness, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, or disability. [42 CFR §422.110(a)]

5. Physician acknowledges that Members of Plan are entitled under federal regulation to directly access, through self-referral, screening mammography and influenza vaccination services and that Plan cannot prohibit direct access to these services. Physician shall cooperate with Plan' procedures to comply with this regulation. [42 CFR §422.100(h)(1)]

6. Physician acknowledges that Members of Plan are prohibited by federal regulation from imposing cost-sharing on Members for influenza and pneumococcal vaccines and that Plan cannot impose cost-sharing on Members for such services. Physician shall cooperate with Plan' procedures to comply with this regulation. [42 CFR §422.100(h)(2)]

7. Plan is required to have procedures to identify Members with complex or serious medical conditions, assess those conditions using medical procedures to diagnose and monitor the conditions on an ongoing basis and establish, implement and periodically update treatment plans for those Members. Physician shall cooperate with Plan's procedures to comply with this regulation. [42 CFR §422.112(a)(4)]

8. Physician shall furnish to Members timely access to care and services that meet or exceed standards established by CMS. Physician shall cooperate in Plan's efforts to monitor timely access to care and services and comply with any necessary corrective action plans to ensure compliance with standards established by CMS. [42 CFR §422.112(a)(8)]

9. Physician shall abide by Plan's procedures to ensure effective and continuous patient care and quality review including Plan's procedures to ensure the performance of a health assessment of all new Members within ninety (90) days of their effective date of enrollment, the maintenance of Members' health records according to professional standards and the exchange information in an appropriate and confidential manner. [42 CFR §422.112(b)(5)]

10. Physician shall provide all covered services to Members in a manner consistent with professionally recognized standards of health care. [42 CFR §422.502(a)(3)(iii)]

11. Physician shall not hold any Member liable for payment of any fees that are the legal obligation of Plan. [42 CFR §422.504(g)(1)(i)]

12. In no event, including, but not limited to, non-payment by Plan, Plan's insolvency or breach of this Agreement, shall Physician bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Member, or person other than Plan acting on a Member's behalf, for services provided pursuant to this Agreement. This Agreement shall not prohibit collection of supplemental charges or co-payments on Plan's behalf made in accordance with the terms of any agreement between Plan and its Members. Further, this provision shall not prohibit the collection of charges for services rendered by Physician but not covered under the Subscriber or Member Agreement and Benefits Schedule. Physician further agrees that (1) this provision shall survive the termination of this Agreement, regardless of the cause giving rise to the termination and shall be construed to be for the benefit of Plan's Members and (2) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Physician and Member or persons acting on Member's behalf. [42 CFR §§422.504(g)(1)(i); 422.504(i)(3)(i)(A)]

13. Physician shall continue to provide covered services to Members in the event of Plan's insolvency, discontinuance of operations or termination of its contract with CMS, for the duration of the contract period for which CMS payments have been made to Plan and, for Members who are hospitalized, until such time as the Member is appropriately discharged from hospital. [42 CFR §§422.504(g)(2)(i); 422.504(g)(2)(ii); 422.504(g)(3)]

14. Plan shall pay Physicians for services rendered to Members in accordance with the terms of the contract between Plan and Health Partners. Any Physician incentive arrangements shall be set forth in the contract between Plan and Health Partners. [42 CFR §422.208]

15. Physician acknowledges that Physician is receiving federal funds from Plan and is subject to laws and regulations applicable to individuals/entities claiming and receiving federal funds. [42 CFR §422.504(h)(2)]

16. If delegated by Plan, Physician and any downstream and related entities shall perform all delegated activities in a manner consistent with applicable federal laws and regulations, Plan's contract with CMS, CMS instructions and any delegation agreement entered into with Plan. Physician shall be delegated only those activities specified in a separate delegation agreement. All delegated activities shall be monitored by Plan on an ongoing basis. Physician acknowledges that Plan is ultimately accountable for any delegated activity and shall have the right to revoke any delegated activity or take corrective action against Physician in the event Physician or any downstream and related entities are not performing the delegated activity or Physician is failing to submit regular reports to Plan on the delegated activity in accordance with the terms of this Agreement, applicable federal laws, rules and regulations, CMS instructions, Plan's contract with CMS or the delegation agreement. In the event that credentialing is delegated to Physician, Physician's credentialing process shall be reviewed and approved by Plan prior to delegation and Plan retains the ultimate right to approve, suspend, terminate or take corrective action against any subcontractor. Physician agrees, and will require any downstream and related entities to agree, that the U.S. Department of Health and Human Services, the Comptroller General or their designees have the right to audit, evaluate and inspect any books, contracts, records, including medical records and documentation of Physician and any downstream and related entities involving transactions related to CMS' contract with Plan. [42 CFR §§422.504(i)(3)(iii); 422.504(i)(4)(i)-(v)]

17. Subject to applicable patient confidentiality laws and regulations, Physician shall submit to Plan or their designees, within thirty (30) calendar days of request therefor, medical records necessary to characterize the content/purpose of each encounter with a Member. In the event that Physician is paid under a capitated arrangement with Plan, Physician shall submit to Plan or their designee, within thirty (30) calendar days of request therefor, all encounter data including medical records necessary to characterize the content/purpose of each encounter with a Member in such frequency, formats and type as reasonably requested by Plan for compliance with reporting requirements of federal and state government agencies and Plan's utilization programs. Upon request by Plan or CMS, Physician shall certify to CMS the accuracy, completeness and truthfulness of the encounter data submitted to Plan or its designee. [42 CFR §§422.502(a)(8); 422.502(l)(2); 422.502(l)(3)]

18. Physician shall cooperate with an independent quality review and improvement organization's activities pertaining to the provision of services to Members. [42 CFR §422.154(a)]

19. Physician shall comply with Plan's medical policy and programs for quality assurance and performance improvement, medical management and utilization review. Plan shall consult with Physician in developing, reviewing or updating such policies and programs and communicating them to other contracted Physicians in accordance with federal laws and regulations. A copy of all such programs shall be provided by Plan to Physician. [42 CFR §§422.202(b); 422.502(a)(5)]

20. In the event that Plan suspends and/or terminates the participation of Physician, Plan shall deliver written notice to Physician of the reason(s) for the suspension and/or termination including, if relevant, the standards and profiling data used to evaluate Physician and the number and mix of Physicians needed by Plan. The notice shall also include the right to appeal the action taken by Plan and the process and timing for requesting a hearing in accordance with Plan's policies and procedures. Physician acknowledges that if Plan suspends and/or terminates the participation of Physician in Plan because of deficiencies in the quality of their care, Plan is required by federal regulations to provide written notice of such action to licensing or disciplinary bodies or to other appropriate authorities. [42 CFR §§422.204(c)(1)]

21. Physician acknowledges that Physician shall abide by any requirement in the contract between Plan and Health Partners to provide at least sixty (60) days prior written notice of termination without cause to Plan. [42 CFR §§422.204(c)(4)]

22. Physician shall comply with all applicable federal laws and regulations including Medicare, Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act, the Rehabilitation Act of 1973, and all other laws applicable to recipients of federal funds. [42 CFR §§422.502(h)(1); 422.502(i)(4)(v)]

23. Physician shall inform Plan immediately upon exclusion from participation in the Medicare program under section 1128 or 1128A of the Social Security Act (SSA) and acknowledges that Plan is prohibited, by federal law, from contracting with a Physician excluded from participation in the Medicare program under section 1128 or 1128A of the SSA, as amended. [42 CFR §422.752(a)(8)]

24. Physician shall cooperate with Plan in the implementation of Plan's grievance and appeals procedures, including Plan's Medicare Member grievance, appeals and expedited appeals procedures, as set forth in the Operating Documents, and will assist Plan in taking appropriate corrective action and gathering and forwarding Member documentation to Plan in a timely manner. Physician will comply with all final determinations made by Plan, CMS, CMS's contracted independent agency or the local peer review organization (PRO) pursuant to such grievance and appeals procedures. Physician understands that Medicare Members are entitled to appeal denial and discharge decisions to an independent entity contracted by CMS or to the PRO. Upon request by Plan, Physician shall promptly deliver to a Member any required denial letter. Physician shall cooperate in the delivery of notice of discharge and Medicare appeal rights or other materials from Plan containing Members' appeal rights and with the parties responsible for performing the review and reconsideration. In addition, Physician shall notify Plan promptly of any decision by Physician not to furnish to a Member a health care service requested by a Member or to terminate or discontinue a health care service being provided to a Member which termination or discontinuation is contrary to the Member's wishes and of any Member grievances and appeals known to Physician. Plan and the PRO will review Members' grievances concerning quality of care. Upon request of Plan, Physician shall investigate and respond promptly to all quality issues related to care provided to Members and cooperate with the PRO and Plan to resolve such issues in the best interest of Members. [42 CFR §422.562(a)]

25. Physician shall comply with Plan's policies, manuals, procedures and instructions. Copies of such documents shall be provided to Physician.

26. Physician acknowledges that Plan oversees and is ultimately accountable to CMS for compliance with the functions and responsibilities described in applicable federal laws and regulations, Plan's contract with CMS and CMS instructions [42 CFR §422.502(i)(3)(ii)(A)]

27. Physician shall refer Members to Plan participating providers and treat members at Plan participating hospitals and providers, unless otherwise expressly authorized by Plan prior to any such referral. If Physician does not have admitting privileges at a Plan participating hospital or provider, Physician shall refer the Member to a Plan participating physician with admitting privileges at a Plan participating hospital or provider. In the event Physician refers a member to or treats a Member at a non-participating hospital or provider, Plan shall not be responsible for payment to Physician for Physician's services and Physician shall not bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Member or a person acting on the Member's behalf for Physician's services. The requirements of this paragraph shall not apply to the emergency medical treatment of a Member.

28. The provisions set forth in this Addendum shall supersede any conflicting provisions of the Physician Services or Participation Agreement.

IN WITNESS WHEREOF, the parties hereto have executed this Addendum effective the day and year first above written.

PHYSICIAN	MOUNT CARMEL HEALTH PARTNERS, LLC an Ohio Limited Liability Company
By: _____ *Signature*	By: _____ VP of Clinical Performance
Name: _____ *Print*	
Practice name: _____	
Tax ID #: _____	
Medicare #: _____	