**CONTRACT WITH ELIGIBLE MEDICARE ADVANTAGE (MA) ORGANIZATION PURSUANT TO SECTIONS 1851 THROUGH 1859 OF THE SOCIAL SECURITY ACT FOR THE OPERATION OF EMPLOYER GROUP ONLY MEDICARE ADVANTAGE NETWORK PRIVATE FEE-FOR-SERVICE PLAN(S)**

CONTRACT (<<CONTRACT_ID>>)

Between

Centers for Medicare & Medicaid Services (hereinafter referred to as "CMS")

and

<<CONTRACT_NAME>>
(hereinafter referred to as the "MA Organization")

CMS and the MA Organization, an entity which has been determined by the Administrator of the Centers for Medicare & Medicaid Services under 42 CFR § 422.503 to be to be eligible as a Medicare Advantage Organization offering one or more MA plans exclusively to Medicare Advantage-eligible individuals enrolled in employment-based health coverage under a contract between the Medicare Advantage Organization and the employer, labor organization, or the trustee(s) of fund(s) established by one or more employers or labor organizations ("employer/union sponsor") that sponsors the employment-based health coverage to furnish benefits to the entity's employees, former employees, or members or former members of the labor organizations, agree to the following for the purposes of §§ 1851 through 1859 of the Social Security Act (hereinafter referred to as "the Act"):

(NOTE: Citations indicated in brackets are placed in the text of this contract to note the regulatory authority for certain contract provisions. All references to Part 422 are to 42 CFR Part 422.)

## Article I
## Term of Contract

The term of this contract shall be from the date of signature by CMS's authorized representative through December 31, 2024, after which this contract may be renewed for successive one-year periods in accordance with 42 CFR § 422.505(c) and as discussed in Paragraph A of Article VII below. **[42 CFR § 422.505]**

This contract governs the respective rights and obligations of the parties as of the effective date set forth above with respect to any network private fee-for-service plan (as defined in 42 CFR § 422.4(a)(3)) offered exclusively to Medicare eligible individuals enrolled in the employer/union sponsor's employment-based health coverage (hereinafter referred to as "PFFS plans") and supersedes any prior agreements between the MA Organization and CMS as of such date.

MA organizations offering Part D benefits also must execute an Addendum to the Medicare Managed Care Contract Pursuant to §§ 1860D-1 through 1860D-43 of the Social Security Act for the Operation of a Voluntary Medicare Prescription Drug Plan (hereinafter the "Part D Addendum"). For MA Organizations offering MA-PD plans to Medicare eligible individuals enrolled in employment-based prescription drug coverage under a contract between the Medicare Advantage Organization and the employer/union sponsor of the employment-based prescription drug coverage, 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
## Network Private Fee-For-Service Plan

A. In accordance with the waivers granted by CMS under § 1857(i) of the Act, the MA Organization agrees to operate one or more Network PFFS plans as described in its final Plan Benefit Package (PBP) bid submission (benefit) proposal as approved by CMS and as attested to in the Medicare Advantage Attestation of Benefit Plan. The MA Organization agrees to comply with the requirements of this contract (which incorporates in its entirety the *2024 Part C-Medicare Advantage and 1876 Cost Plan Expansion Application* (released on January 10, 2023)), §§ 1851 through 1859 of the Act, the regulations at 42 CFR Part 422, and all other applicable Federal statutes and regulations and the policies outlined in guidance, such as the Medicare Managed Care Manual, the Medicare Communications and Marketing Guidelines, CMS Participant Guides, Health Plan Management System memos, Rate Announcement, and trainings. The MA Organization agrees to comply with any employer/union-only group waiver guidance issued by CMS, including, but not limited to, those requirements and limits on waivers set forth in Chapter 9 of the Medicare Managed Care Manual (hereinafter referred to as "employer/union group waiver guidance").

B. The MA Organization agrees that it has not applied for, and is not authorized to operate, Network PFFS plans offered to individual Medicare beneficiaries under this contract.

C. Except as provided in paragraph (F) of this Article, this contract is deemed to incorporate any changes that are required by statute to be implemented during the term of the contract and any regulations implementing or interpreting such statutory provisions.

D. CMS agrees to perform its obligations to MA Organization consistent with the requirements of this contract, §§ 1851 through 1859 of the Act, the regulations at 42 CFR Part 422, and all other applicable Federal statutes and regulations.

E. If the MA Organization had a contract with CMS for Contract Year 2023 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 2023 contract, the parties' execution of this contract does not extinguish or interrupt any pending obligations or actions that may have arisen under the 2023 or prior year contracts.

F. CMS will not implement, other than at the beginning of a calendar year, requirements under 42 CFR Part 422 that impose a new significant cost or burden on MA organizations or plans, unless a different effective date is required by statute. **[42 CFR § 422.521]**

G. In the event of any conflict between employer/union group waiver guidance issued prior to the execution of the contract and this contract, the provisions of this contract shall control. In the event of any conflict between the employer/union group waiver guidance issued after the execution of the contract, the provisions of the employer/union group waiver guidance shall control.

H. This contract is in no way intended to supersede or modify 42 CFR Part 422. Failure to reference a regulatory requirement in this contract does not affect the applicability of such requirements to the MA Organization and CMS.

## Article III
## Functions To Be Performed By Medicare Advantage Organization

A. PROVISION OF BENEFITS

1. The MA Organization agrees to provide enrollees in each of its MA plans the basic benefits as required under 42 CFR §§ 422.100 and 422.101 and, to the extent applicable, supplemental benefits under 42 CFR § 422.102 and as established in the MA Organization's final plan benefit package proposal as approved by CMS and listed in the Medicare Advantage Attestation of Benefit Plan, which is included in the contract materials. The MA Organization agrees to provide access to such benefits as required under subpart C in a manner consistent with professionally recognized standards of health care and according to the access standards stated in 42 CFR § 422.114. **[42 CFR § 422.504(a)(3)]**

2. The MA Organization acknowledges and agrees that payment under Part C of Title XVIII for Part A and B services, including rebates under section 1854 of the Social Security

Act, provided to enrollees in its employer/union-only group MA-PDs will be governed by the CY 2024 Rate Announcement issued on March 31, 2023.

3. The MA Organization agrees enrollees of its employer group only PFFS plans will not be permitted to make payment of premiums under 42 CFR § 422.262(f) through withholding from the enrollee's Social Security, Railroad Retirement Board, or Office of Personnel Management benefit payment.

4. For any employer group only PFFS plans that have a monthly beneficiary rebate described in 42 CFR § 422.266:

   (a) The MA Organization may vary the form of rebate for a particular plan benefit package so that the total monthly rebate amount may be credited differently for each employer/union group to whom the MA Organization offers the plan benefit package; and

   (b) The MA Organization must retain documentation that supports the use of all of the rebates on a detailed basis for each employer/union group within the plan benefit package and must provide access to this documentation access to this documentation in accordance with the requirements of 42 CFR §§ 422.503(d) and 422.504(d) through (f). .

5. For non-calendar year employer group only PFFS plans, the MA Organization may determine Part C benefits (including deductibles, out-of-pocket limits, etc.) on a non-calendar year basis subject to the following requirements:

   (a) Applications, plan benefit packages, and other submissions to CMS must be submitted on a calendar year basis; and

   (b) The coverage under the employer group PFFS plan must be at least actuarially equivalent to Medicare fee-for-service coverage for the portion of its plan year that falls in a given calendar year. The MA Organization will meet this standard if its coverage under the employer group PFFS plan is at least actuarially equivalent for the calendar year in which the employer group plan year starts and no design change is made for the remainder of the plan year.

B. PREMIUM REQUIREMENTS

1. Except as provided in this paragraph, the MA Organization agrees to calculate and collect beneficiary premiums in accordance with 42 CFR § 422.262.

2. The MA Organization agrees that enrollees of its employer group only PFFS plans shall not be charged more than the sum of his or her monthly beneficiary premium attributable to basic benefits provided under the plan as defined in 42 CFR §§ 422.2 and 422.100(c) (i.e., all Medicare-covered benefits, except hospice services and costs of kidney

acquisitions for transplant) and 100% of the monthly beneficiary premium attributable to his or her non-Medicare Part C benefits other than prescription drug coverage (if any). The MA Organization must pass through the monthly payments described under 42 CFR § 422.304(a) received from CMS to reduce the amount that the enrollee pays (or, in those instances where the subscriber to or participant in the employer plan pays premiums on behalf of a Medicare eligible spouse or dependent, the amount the subscriber or participant pays).

3. The MA Organization agrees enrollees of its employer group only PFFS plans will not be permitted to make payment of premiums under 42 CFR § 422.262(f) through withholding from the enrollee's Social Security, Railroad Retirement Board, or Office of Personnel Management benefit payment.

4. The MA Organization agrees it shall obtain written agreements from each employer/union that provide that the employer/union may determine how much of an enrollee's Part C monthly beneficiary premium it will subsidize, subject to the restrictions set forth in this paragraph. The MA Organization agrees to retain these written agreements with employers/unions and must provide access to this documentation for inspection or audit by CMS (or its designee) in accordance with the requirements of 42 CFR §§ 422.503(d) and 422.504(d) and (e).

   (a) The employer/union can subsidize different amounts for different classes of enrollees in the employer group only PFFS plan provided such classes are reasonable and based on objective business criteria, such as years of service, date of retirement, business location, job category, and nature of compensation (e.g., salaried v. hourly).

   (b) The employer/union cannot vary the premium subsidy for individuals within a given class of enrollees.

   (c) The employer/union cannot charge an enrollee for coverage provided under the employer group only PFFS plan more than the sum of his or her monthly beneficiary premium attributable to basic benefits provided under the plan as defined in 42 CFR §§ 422.2 and 422.100(c) (i.e., all Medicare-covered benefits, except hospice services and costs of kidney acquisitions for transplant) and 100% of the monthly beneficiary premium attributable to his or her non-Medicare Part C benefits (if any). The MA Organization must pass through the monthly payments described under 42 CFR § 422.304(a) received from CMS to reduce the amount that the enrollee pays (or, in those instances where the subscriber to or participant in the employer plan pays premiums on behalf of a Medicare eligible spouse or dependent, the amount the subscriber or participant pays).

C. ENROLLMENT REQUIREMENTS

1. Except as provided in subparagraphs C.2 through C.6 of this Article, the MA Organization agrees to accept new enrollments, make enrollments effective, process

voluntary disenrollments, and limit involuntary disenrollments, as provided in 42 CFR Part 422 Subpart B. **[42 CFR § 422.504(a)(1)]**

2. The MA Organization agrees to restrict enrollment in its employer group only PFFS plans to those Medicare Advantage-eligible individuals eligible for the employer's/union's employment-based health coverage.

3. The MA Organization is not subject to the requirement to offer its employer group only PFFS plans to all Medicare Advantage-eligible beneficiaries residing in the plan's service area as set forth in 42 CFR § 422.100(d)(1).

4. The MA Organization is not subject to the minimum enrollment requirements set forth in 42 CFR § 422.514(a).

5. If the MA Organization elects to enroll Medicare Advantage-eligible individuals eligible for its employer group only PFFS plans through a group enrollment process, the MA Organization is not subject to the individual enrollment requirements set forth in 42 CFR § 422.60(c). The MA Organization agrees that it will comply with all the requirements for group enrollment contained in CMS guidance, including those requirements contained in the MA Enrollment and Disenrollment Guidance.

6. The requirements in § 1852 of the Act and 42 CFR § 422.100(c)(1) pertaining to the offering of benefits covered under Medicare Part A, and in § 1851 of the Act and 42 CFR § 422.50(a)(1) pertaining to who may enroll in an MA-PD, are waived for MA-PD enrollees who are not entitled to Medicare Part A.

7. The MA Organization shall comply with the provisions of 42 CFR § 422.110 concerning prohibitions against discrimination in beneficiary enrollment. **[42 CFR § 422.504(a)(2)]**

D. BENEFICIARY PROTECTIONS

1. The MA Organization agrees to comply with all requirements in 42 CFR Part 422 Subpart M governing coverage determinations, grievances, and appeals. **[42 CFR § 422.504(a)(7)]**

2. The MA Organization agrees to comply with the confidentiality and enrollee record accuracy requirements in 42 CFR § 422.118. **[42 CFR § 422.504(a)(13)]**

3. Beneficiary Financial Protections. The MA Organization agrees to comply with the following requirements:

   (a) The MA Organization must adopt and maintain arrangements satisfactory to CMS to protect its enrollees from incurring liability for payment of any fees that are the legal obligation of the MA Organization—in accordance with the requirements of 42 CFR § 422.504(g)(1).

(b) Ensure that in the MA Organization's terms and conditions of payment to hospitals, if balance billing is imposed, the hospitals are obligated to provide notice to enrollees of their potential liability for services where balance billing could amount to not less than $500. This notice shall be provided according to the requirements of 42 CFR § 422.216(d)(2).

(c) The MA Organization must provide for continuation of enrollee health care benefits as required by 42 CFR § 422.504(g)(2).

(d) In meeting the requirements of this paragraph, other than the provider contract requirements specified in 42 CFR § 422.504(g)(1), the MA Organization may use—

(i) Contractual arrangements;

(ii) Insurance acceptable to CMS;

(iii) Financial reserves acceptable to CMS; or

(iv) Any other arrangement acceptable to CMS. **[42 CFR § 422.504(g)(3)]**

E. PROVIDER PROTECTIONS

1. The MA Organization agrees to comply with all applicable requirements for health care providers, including physicians, practitioners, providers of services (as defined in section 1861 of the Act), and suppliers, in 42 CFR Part 422 Subpart E, including provider certification requirements, anti-discrimination requirements, provider participation and consultation requirements, the prohibition on interference with provider advice, limits on provider indemnification, rules governing payments to providers, limits on physician incentive plans, and preclusion list requirements in 42 CFR §§ 422.222 and 422.224. **[42 CFR § 422.504(a)(6)]**

2. The MA Organization agrees to comply with the prompt payment provisions of 42 CFR § 422.520 and with instructions issued by CMS as they apply to the type of plan included in the contract. **[42 CFR § 422.504(c)]**

(a) The MA Organization must pay 95 percent of "clean claims" within 30 days of receipt if they are claims for covered services submitted by, or on behalf of, an enrollee of an MA private fee-for-service plan or are claims for services that are not furnished under a written agreement between the organization and the provider. The term clean claim is defined in accordance with 42 CFR § 422.500.

(i) The MA Organization must pay interest on clean claims that are not paid within 30 days in accordance with §§ 1816(c)(2) and 1842(c)(2) of the Act.

(ii) All other claims from non-contracted providers must be paid or denied within 60 calendar days from the date of the request. **[42 CFR § 422.520(a)]**

3. Payment Rates:

   (a) The MA Organization shall establish payment rates sufficient to ensure access as required by 42 CFR § 422.114.

   (b) CMS and the MA Organization shall reach agreement, on or before the effective date of this contract, on provider payment methodologies, which shall include provider payment proxies, also described as estimated Original Medicare payment amounts.

   (c) The MA Organization agrees to implement revised provider payment schedules on the same date that such changes are required of contractors administering the Original Medicare benefit.

   (d) The MA Organization agrees that it shall revise its provider payment schedule to reflect the requirements of legislative or regulatory changes made during the term of this contract. Also, the MA Organization agrees that CMS may require the MA Organization to revise its provider payment schedule if CMS determines that the existing schedule does not comply with the provisions of 42 CFR § 422.114(a)(2). **[42 CFR § 422.114]**

   (e) The MA Organization agrees that it shall establish and maintain a payment appeal system under which MA plan providers may have their payment claims reviewed in the event that the provider believes they were paid less than they would have been paid under Original Medicare. Under such a system, if a provider reasonably demonstrates that they have not received proper payment, the MA Organization shall pay the provider the difference between what the provider had received and what they would have received under Original Medicare.

   (f) The MA Organization agrees to make its provider payment schedule available to the public in such a manner as to allow providers a reasonable opportunity to be informed about payment methodologies under the MA plan. This includes posting the schedule on a Web site maintained by the MA Organization.

4. Agreements with Federally Qualified Health Centers (FQHC)

   (a) The MA Organization agrees to pay an FQHC a similar amount to what it pays other providers for similar services.

   (b) Under such a contract, the FQHC must accept this payment as payment in full, except for allowable cost sharing which it may collect.

(c) Financial incentives, such as payments or bonuses, and financial withholdings are not considered in determining the payments made by CMS under 42 CFR § 422.316(a). **[42 CFR § 422.527]**

F. QUALITY REQUIREMENTS

1. The MA Organization agrees to operate a quality assurance and performance improvement program, including provisions for the collection, maintenance and submission of health and performance data, and have an agreement for external quality review as applicable for each type of plan included in the contract and as required by 42 CFR Part 422 Subpart D. **[42 CFR § 422.504(a)(5)]**

2. The MA Organization agrees to address complaints received by CMS against the MA Organization through the CMS complaint tracking system. **[42 CFR § 422.504(a)(15)]**

G. COMPLIANCE PLAN

The MA Organization agrees to implement a compliance plan in accordance with the requirements of 42 CFR § 422.503(b)(4)(vi). **[42 CFR § 422.503(b)(4)(vi)]**

H. PROGRAM INTEGRITY

1. The MA Organization agrees to provide notice based on best knowledge, information, and belief to CMS of any integrity items related to payments from governmental entities, both federal and state, for healthcare or prescription drug services. These items include any investigations, legal actions or matters subject to arbitration brought involving the MA Organization (or the MA Organization's firm if applicable) and its subcontractors (excluding contracted network providers), including any key management or executive staff, or any major shareholders (5% or more), by a government agency (state or federal) on matters relating to payments from governmental entities, both federal and state, for healthcare and/or prescription drug services. In providing the notice, the sponsor shall keep the government informed of when the integrity item is initiated and when it is closed. Notice should be provided of the details concerning any resolution and monetary payments as well as any settlement agreements or corporate integrity agreements.

2. The MA Organization agrees to provide notice based on best knowledge, information, and belief to CMS in the event the MA Organization or any of its subcontractors is criminally convicted or has a civil judgment entered against it for fraudulent activities or is sanctioned under any Federal program involving the provision of health care or prescription drug services.

I. DISCLOSURE OF PLAN INFORMATION

1. The MA Organization must disclose the information to each enrollee electing a plan as outlined in 42 CFR § 422.111. **[42 CFR §§ 422.111 and 422.504(1)(4)]**

2. Except as provided in subparagraph 3 of this paragraph, CMS agrees that with respect to its employer group only PFFS plans, the MA Organization is not subject to the information requirements set forth in 42 CFR § 422.64 and the prior review and approval of disclosure materials and election forms requirements set forth in 42 CFR Part 422 Subpart V. The MA Organization is subject to all other disclosure requirements contained in 42 CFR § 422.111 and that are conditions of any waivers for employer group waiver plans (EGWPs) in CMS guidance in Chapter 9 of the Medicare Managed Care Manual.

3. CMS agrees that the disclosure requirements set forth in 42 CFR § 422.111 do not apply with respect to the MA Organization's employer group only PFFS plans when the employer/union sponsor is subject to alternative disclosure requirements (e.g., the Employee Retirement Income Security Act of 1974 ("ERISA")) and fully complies with such alternative requirements. The MA Organization agrees to comply with the conditions of this waiver contained in employer/union group waiver guidance in Chapter 9 of the Medicare Managed Care Manual.

## Article IV
## CMS Payment to MA Organization

A. The MA Organization agrees to develop its annual benefit and price bid proposal and submit to CMS all required information on premiums, benefits, and cost sharing, as required under 42 CFR Part 422 Subpart F and modified for EGWPs by the annual Plan Benefit Package and Bid Pricing Tool Software and Related Technical Bidding Guidance. **[42 CFR § 422.504(a)(10)]**

B. METHODOLOGY

CMS agrees to pay the MA Organization, and MA Organization agrees that it will be paid, under this contract in accordance with the provisions of § 1853 of the Act and 42 CFR Part 422 Subpart G, as adopted for employer group waiver plans in the CY 2024 Rate Announcement issued on March 31, 2023. **[42 CFR § 422.504(a)(9)]**

C. ELECTRONIC HEALTH RECORDS INCENTIVE PROGRAM

The MA Organization agrees to abide by the requirements in 42 CFR §§ 495.200 et seq. and § 1853(m) of the Act.

D. ATTESTATION OF PAYMENT DATA

As a condition for receiving a monthly payment under paragraph B of this article, and 42 CFR Part 422 Subpart G, the MA Organization agrees that its chief executive officer (CEO), chief financial officer (CFO), or an individual delegated with the authority to sign on behalf of one of these officers, and who reports directly to such officer, must request payment under the contract on the forms provided through HPMS, titled as "*Attestation of Enrollment Information Relating to CMS Payment to a Medicare Advantage Organization"* and

"*Attestation of Risk Adjustment Data Information Relating to CMS Payment to a Medicare Advantage Organization."* Additionally, the Medicare Advantage Plan Attestation of Benefit Plan, which is included in the contract materials, must be signed, and attached to the executed version of this contract. **[42 CFR § 422.504(l)]**
**(NOTE: CMS will provide instructions for the completion and submission of the forms in separate documents. The MA Organization should not take any action on the forms until appropriate CMS instructions become available.)**

## Article V
## MA Organization Relationship with Related Entities, Contractors, and Subcontractors

A. All references to "first tier, downstream, and related entities" and "contracts" in this Article shall include deemed contract providers (where applicable) and arrangements with deemed contract providers as described in 42 CFR § 422.216(f).

B. Notwithstanding any relationship(s) that the MA Organization may have with first tier, downstream, or related entities, the MA Organization maintains full responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS. **[42 CFR § 422.504(i)(1)]**

C. The MA Organization agrees to require all first tier, downstream, and related entities to agree to the following:

1. The Department of Health and Human Services (HHS), the Comptroller General, or their designees have the right to audit, evaluate, collect, and inspect any books, contracts, computer or other electronic systems, including medical records and documentation of the first tier, downstream, and related entities related to CMS's contract with the MA Organization;

2. HHS, the Comptroller General, or their designees have the right to audit, evaluate, collect, and inspect any records under paragraph C(1) of this Article directly from any first tier, downstream, or related entity;

3. For records subject to review under paragraph C(2) of this Article, except in exceptional circumstances, CMS will provide notification to the MA Organization that a direct request for information has been initiated;

4. HHS, the Comptroller General, or their designees have the right to inspect, evaluate, and audit any pertinent information for any particular contract period for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later; and

5. They will ensure that payments are not made to individuals and entities included on the preclusion list, defined in 42 CFR § 422.2, in accordance with the provisions in 42 CFR §§ 422.222 and 422.224. **[42 CFR § 422.504(i)(2)]**

D. The MA Organization agrees that all contracts or written arrangements into which the MA Organization enters with first tier, downstream, or related entities shall contain the provisions required by 42 CFR § 422.504(i)(3).

E. If any of the MA Organization's activities or responsibilities under this contract with CMS are delegated to other parties, all contracts or written arrangements with any first tier, downstream, or related entity must meet the requirements of 42 CFR § 422.504(i)(4).

F. If the MA Organization delegates selection of the providers, contractors, or subcontractors to another organization, the MA Organization's contract with that organization must state that the CMS-contracting MA Organization retains the right to approve, suspend, or terminate any such arrangement. **[42 CFR § 422.504(i)(5)]**

G. The MA Organization shall not operate a physician incentive plan for any MA private fee-for-service plan. [**42 CFR § 422.208(e)].**

## Article VI
## Records Requirements

A. MAINTENANCE OF RECORDS

1. The MA Organization agrees to maintain for 10 years books, records, documents, and other evidence of accounting procedures and practices in accordance with the requirements of 42 CFR § 422.504(d).

2. Access to facilities and records.

   (a) The MA Organization agrees that HHS, the Comptroller General, or their designee may evaluate, audit, and inspect the records and facilities of the MA Organization in accordance with 42 CFR § 422.504(e)(1)-(3).

   (b) The right extends through 10 years from the final date of the contract period or completion of audit, whichever is later, except as provided in 42 CFR § 422.504(e)(4).

B. REPORTING REQUIREMENTS

1. The MA Organization agrees to comply with the reporting requirements in 42 CFR § 422.516 and the requirements in 42 CFR § 422.310 for submitting data to CMS. **[42 CFR § 422.504(a)(8)]**

2. The MA Organization agrees to submit to CMS and, as applicable, its enrollees information as described in 42 CFR § 422.504(f).

3. Electronic communication. The MA Organization must have the capacity to communicate with CMS electronically. **[42 CFR § 422.504(b)]**

4. The MA Organization acknowledges that CMS releases to the public the following data, consistent with 42 CFR Part 422 Subpart K, and 42 CFR Part 423 Subpart K:

   (a) summary reconciled Part C and Part D payment data after the reconciliation of Part C and Part D payments, as provided in 42 CFR § 422.504(n)(1) and 42 CFR § 423.505(o)(1);

   (b) MA bid pricing data submitted during the annual bidding process, as described at 42 CFR § 422.272;

   (c) Part C Medical Loss Ratio data for the contract year, as described at 42 CFR § 422.2490, and, for Part D plan sponsors, Part D Medical Loss Ratio data for the contract year, as described at 42 CFR § 423.2490. **[42 CFR § 422.504(n)]**

## Article VII
## Renewal of the MA Contract

A. RENEWAL OF CONTRACT

In accordance with 42 CFR § 422.505, following the initial contract period, this contract is renewable annually only if-

1. The MA Organization has not provided CMS with a notice of intention not to renew; **[42 CFR § 422.506(a)]**

2. CMS and the MA Organization reach agreement on the bid under 42 CFR Part 422 Subpart F; and **[42 CFR § 422.505(d)]**

3. CMS has not provided the MA Organization with notice of its intention not to renew.

B. NONRENEWAL OF CONTRACT

1. In accordance with 42 CFR § 422.506, the MA Organization may elect not to renew its contract with CMS as of the end of the term of the contract for any reason, provided it meets the timeframes for doing so set forth in this subparagraph.

2. If the MA Organization does not intend to renew its contract, it must notify--

   (a) CMS, in writing, by the first Monday in June of the year in which the contract would end, pursuant to 42 CFR § 422.506.

   (b) Each Medicare enrollee by mail, at least 90 calendar days before the date on which the nonrenewal is effective. This notice must include a written description of all alternatives available for obtaining Medicare services within the service area including alternative MA plans, MA-PD plans, Medigap options, and original Medicare and prescription drug plans (PDPs) and must receive CMS approval prior to issuance.

3. If the MA organization submits a request to end the term of its contract after the deadline in 42 CFR § 422.506, CMS and the MA Organization may mutually consent to terminate the contract pursuant to 42 CFR § 422.508 when a nonrenewal notice is submitted after the applicable annual nonrenewal notice deadline if –

   (a) The contract termination does not negatively affect the administration of the Medicare program;

   (b) The MA Organization notifies its Medicare of any changes that CMS determines are appropriate for notification within the timeframes specified by CMS; and

   (c) Included as a provision of the termination agreement is language prohibiting the MA organization from applying for new contracts or service area expansions for a period of 2 years, absent circumstances warranting special consideration. This prohibition may apply regardless of the product type, contract type, or service area of the previous contract.

4. If the MA Organization does not renew a contract under this subparagraph or if a contract is mutually terminated, CMS may deny an application for a new contract or a service area expansion from the MA Organization or with any organization whose covered persons, as defined at 42 CFR §§ 422.506(a)(4) and 422.508(d), also served as covered persons for the nonrenewing MA Organization for 2 years unless there are special circumstances that warrant special consideration, as determined by CMS. This prohibition may apply regardless of the product type, contract type, or service area of the previous contract. **[42 CFR §§ 422.506(a)(4) and 422.508(c) and (d)]**

## Article VIII
## Modification or Termination of the Contract

A. MODIFICATION OR TERMINATION OF CONTRACT BY MUTUAL CONSENT

1. This contract may be modified or terminated at any time by written mutual consent.

   (a) If the contract is modified by written mutual consent, the MA Organization must notify its Medicare enrollees of any changes that CMS determines are appropriate for notification within the timeframes specified by CMS. **[42 CFR § 422.508(a)(2)]**

   (b) If the contract is terminated by written mutual consent, except as provided in subparagraph 2 of this paragraph, the MA Organization must provide notice to its Medicare enrollees and the general public as provided in paragraph B, subparagraph 2(b) of this Article. **[42 CFR § 422.508(a)(1)]**

2. If this contract is terminated by written mutual consent and replaced the day following such termination by a new MA contract, the MA Organization is not required to provide the notice specified in paragraph B of this Article. **[42 CFR § 422.508(b)]**

3. As a condition of the consent to a mutual termination, CMS will require as a provision of the termination agreement language prohibiting the MA Organization from applying for new contracts or service area expansions for a period of 2 years, absent circumstances warranting special consideration. This prohibition may apply regardless of the product type, contract type, or service area of the previous contract. **[42 CFR § 422.508(c)]**

B. TERMINATION OF THE CONTRACT BY CMS OR THE MA ORGANIZATION

1. Termination by CMS.

   (a) CMS may at any time terminate a contract if CMS determines that the MA Organization meets any of the following: **[42 CFR § 422.510(a)(1)-(3)]**

      (i) Has failed substantially to carry out the terms of its contract with CMS.

      (ii) Is carrying out its contract in a manner that is inconsistent with the efficient and effective implementation of 42 CFR Part 422.

      (iii)No longer substantially meets the applicable conditions of 42 CFR Part 422.

   (b) CMS may make a determination under paragraph B(1)(a)(i), (ii), or (iii) of this Article if the MA Organization has had one or more of the conditions listed in 42 CFR § 422.510(a)(4) occur.

   (c) Notice. If CMS decides to terminate a contract, it will give notice of the termination as follows: **[42 CFR § 422.510(b)(1)]**

(i) CMS will notify the MA Organization in writing at least 45 calendar days before the intended date of the termination.

(ii) The MA Organization will notify its Medicare enrollees of the termination by mail at least 30 calendar days before the effective date of the termination.

(iii) The MA Organization will notify the general public of the termination at least 30 calendar days before the effective date of the termination by releasing a press statement to news media serving the affected community or county and posting the press statement prominently on the organization's Web site.

(iv) In the event that CMS issues a termination notice to the MA Organization on or before August 1 with an effective date of the following December 31, the MA Organization must issue notification to its Medicare enrollees at least 90 days prior to the effective date of termination.

(d) Expedited termination of contract by CMS. **[42 CFR § 422.510(b)(2)]**

(i) For terminations based on violations prescribed 42 CFR § 422.510(a)(4)(i), if the MA Organization experiences financial difficulties so severe that its ability to make necessary health services available is impaired to the point of posing an imminent and serious risk to the health of its enrollees, or otherwise fails to make services available to the extent that such a risk to health exists, or if CMS determines that a delay in termination would pose an imminent and serious threat to the health of the individuals enrolled with the MA Organization, CMS will notify the MA Organization in writing that its contract has been terminated on a date specified by CMS. If a termination is effective in the middle of a month, CMS has the right to recover the prorated share of the capitation payments made to the MA Organization covering the period of the month following the contract termination.

(ii) CMS will notify the MA Organization's Medicare enrollees in writing of CMS's decision to terminate the MA Organization's contract. This notice will occur no later than 30 days after CMS notifies the MA Organization of its decision to terminate this contract. CMS will simultaneously inform the Medicare enrollees of alternative options for obtaining Medicare services, including alternative MA Organizations in a similar geographic area and original Medicare.

(iii) CMS will notify the general public of the termination no later than 30 days after notifying the MA Organization of CMS's decision to terminate this contract. This notice will be published in one or more newspapers of general circulation in each community or county located in the MA Organization's service area.

(e) Corrective action plan **[42 CFR § 422.510(c)]**

(i) General. Before providing a notice of intent to terminate a contract for reasons other than the grounds specified in subparagraph 1(d)(i) of this paragraph, CMS will provide the MA Organization with notice specifying the MA Organization's deficiencies and a reasonable opportunity of at least 30 calendar days to develop and implement a corrective action plan to correct the deficiencies that are the basis of the proposed termination.

(ii) Exceptions. If a contract is terminated under subparagraph 1(d)(i) of this paragraph, the MA Organization will not be provided with the opportunity to develop and implement a corrective action plan.

(f) Appeal rights. If CMS decides to terminate this contract, it will send written notice to the MA Organization informing it of its termination appeal rights in accordance with 42 CFR Part 422 Subpart N. **[42 CFR § 422.510(d)]**

2. Termination by the MA Organization [**42 CFR § 422.512]**

(a) Cause for termination. The MA Organization may terminate this contract if CMS fails to substantially carry out the terms of the contract.

(b) Notice. The MA Organization must give advance notice as follows:

(i) To CMS, at least 90 days before the intended date of termination. This notice must specify the reasons why the MA Organization is requesting contract termination.

(ii) To its Medicare enrollees, at least 60 days before the termination effective date. This notice must include a written description of alternatives available for obtaining Medicare services within the service area, including alternative MA and MA-PD plans, PDPs, Medigap options, and original Medicare and must receive CMS approval.

(iii)To the general public at least 60 days before the termination effective date by publishing a CMS-approved notice in one or more newspapers of general circulation in each community or county located in the MA Organization's geographic area.

(c) Effective date of termination. The effective date of the termination will be determined by CMS and will be at least 90 days after the date CMS receives the MA Organization's notice of intent to terminate.

(d) CMS's liability. CMS's liability for payment to the MA Organization ends as of the first day of the month after the last month for which the contract is in effect, but CMS shall make payments for amounts owed prior to termination but not yet paid.

(e) Effect of termination by the organization. CMS may deny an application for a new contract or service area expansion from the MA Organization or with an organization whose covered persons, as defined in 42 CFR § 422.512(e)(2), also served as covered persons for the terminating MA Organization for a period of 2 years from the date the Organization has terminated this contract, unless there are circumstances that warrant special consideration, as determined by CMS. This prohibition may apply regardless of the product type, contract type, or service area of the previous contract. **[42 CFR § 422.512]**

## Article IX
## Requirements of Other Laws and Regulations

A. The MA Organization agrees to comply with –

1. Federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including, but not limited to, applicable provisions of Federal criminal law, the False Claims Act (31 USC §§ 3729 et seq.), and the anti-kickback statute (§ 1128B(b) of the Act): and

2. Health Insurance Portability and Accountability Act (HIPAA) administrative simplification rules at 45 CFR Parts 160, 162, and 164. **[42 CFR § 422.504(h)]**

B. Pursuant to § 13112 of the American Recovery and Reinvestment Act of 2009 (ARRA), the MA Organization agrees that as it implements, acquires, or upgrades its health information technology systems, it shall utilize, where available, health information technology systems and products that meet standards and implementation specifications adopted under § 3004 of the Public Health Service Act, as amended by § 13101 of the ARRA.

C. The MA Organization maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS, notwithstanding any relationship(s) that the MA Organization may have with first tier, downstream and related entities, including contractors and subcontractors. **[42 CFR § 422.504(i)]**

D. In the event that any provision of this contract conflicts with the provisions of any statute or regulation applicable to an MA organization, the provisions of the statute or regulation shall have full force and effect unless those provisions have been waived or modified by CMS as described in applicable employer/union group waiver guidance.

E. The MA 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.

## Article X
## Severability

The MA Organization agrees that, upon CMS's request, this contract will be amended to exclude any MA plan, segment of any MA plan, or State-licensed entity specified by CMS, and a separate contract for any such excluded plan, segment, or entity will be deemed to be in place when such a request is made. **[42 CFR § 422.504(k)]**

## Article XI
## Miscellaneous

A. DEFINITIONS

Terms not otherwise defined in this contract shall have the meaning given to such terms in 42 CFR Part 422.

B. ALTERATION TO ORIGINAL CONTRACT TERMS

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

C. MA Organization agrees to maintain a fiscally sound operation by at least maintaining a positive net worth (total assets exceed total liabilities) as required in 42 CFR § 422.504(a)(14).

D. MA Organization agrees to maintain administrative and management capabilities sufficient for the organization to organize, implement, and control the financial, marketing, benefit administration, and quality improvement activities related to the delivery of Part C services as required by 42 CFR § 422.504(a)(16).

E. MA Organization agrees to maintain a Part C summary plan rating score of at least 3 stars under the 5-star rating system specified in 42 CFR Part 422 subpart D, as required by 42 CFR § 422.504(a)(17).

F. CMS may determine that the MA Organization is out of compliance with a Part C requirement and take compliance actions as described in 42 CFR § 422.504(m) or issue intermediate sanctions as defined in 42 CFR Part 422 Subpart O. **[42 CFR § 422.504(m)]**

G. The MA Organization agrees to comply with all requirements that are specific to a particular type of MA plan offered under this contract, such as the special rules for private fee-for-service plans in 42 CFR §§ 422.114 and 422.216; the rules for special needs plans in 42 CFR §§ 422.101(f), 422.107, 422.152(g,) and 422.629 through 422.634; and the MSA requirements in 42 CFR §§ 422.56, 422.103, and 422.262

H. The MA Organization agrees to comply with the requirements for access to health data and plan information in 42 CFR §§ 422.119 and 422.120. **[42 CFR § 422.504(a)(18)]**

I. **Business Continuity**: The MA organization agrees to develop, maintain, and implement a business continuity plan as required by 42 CFR § 422.504(o).

J. The MA Organization agrees not to establish a segment of an MA plan that meets the criteria in § 422.514(d).

In witness whereof, the parties hereby execute this contract.

This document has been electronically signed by:

FOR THE MA 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